

Canadian Hospital

Montreal Children's Hospital

- ***Lay-out***
- ***Nursing program***
- ***Research activities***
- ***Mental guidance clinic***
- ***School and social service***
- ***Physical and occupational therapy***

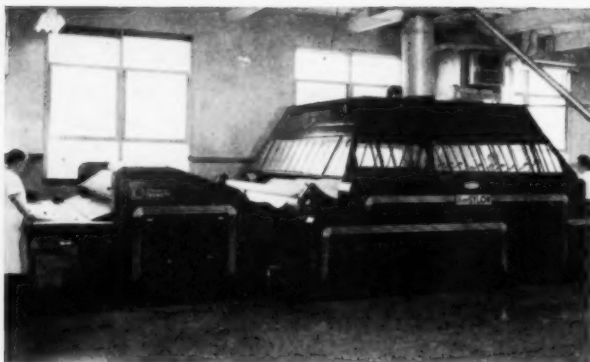
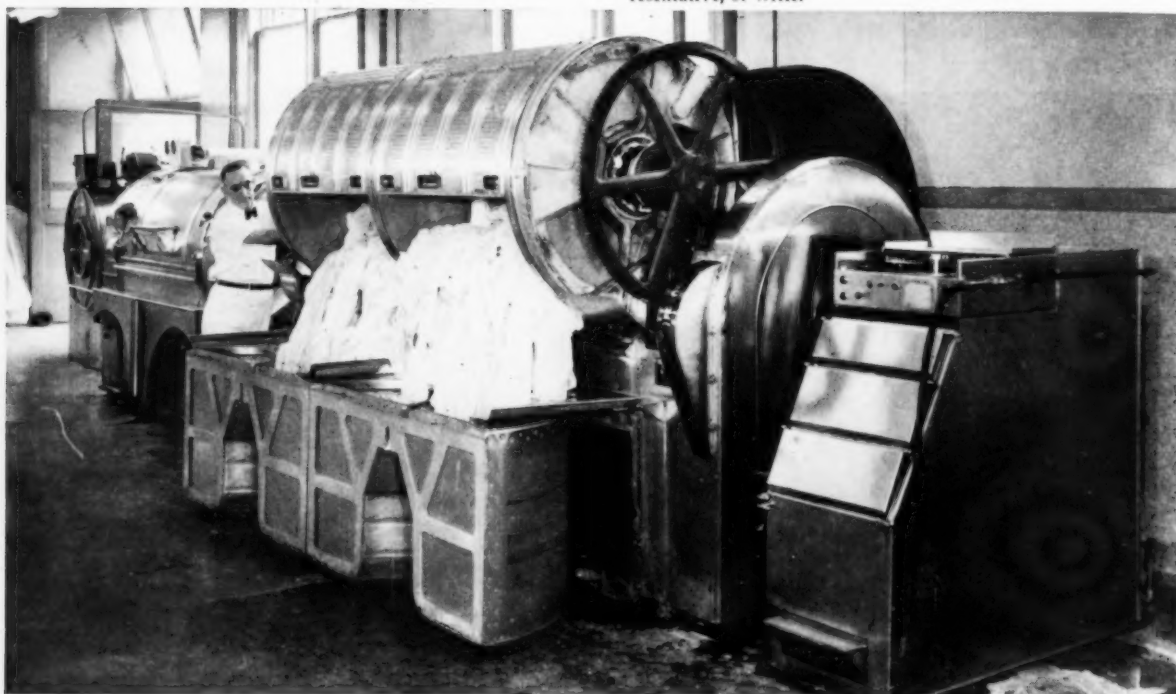


Canadian Hospital Association

Report from Brantford General Hospital, Brantford, Ontario

Laundry costs down \$600 per week with modern Canadian labor-saving equipment

Now, at the 378-bed Brantford General Hospital, pushbuttons handle former backbreaking laundry chores—thanks to new Canadian equipment. Automatic controls regulate work, practically eliminate manual operations. This adventure into modern, efficient laundry techniques has paid handsome dividends. Production is up 40%—weekly volume approaches 11 tons. At the same time, labor costs have dropped \$500 *per week!* Added to this is a \$50 weekly savings in supplies, better quality work, improved working conditions and faster return of linens to service. This is one example of what Canadian laundry planning and automatic machinery can do. For complete information, contact your nearest Canadian representative, or write.



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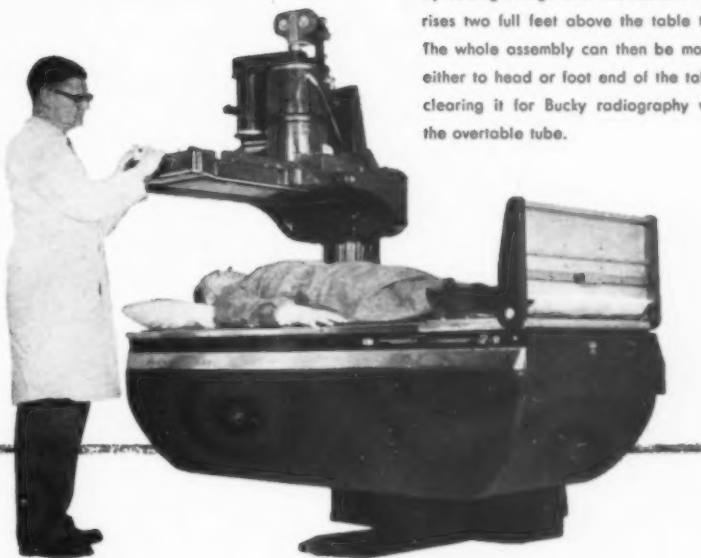
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◀ Notes About People ▶

Blue Cross Appointment

E. Duncan Millican, President, Quebec Hospital Service Association, Montreal, has been named to the Blue Cross Commission, succeeding F. D. MacCharles, Executive Director, Manitoba Hospital Service Association, Winnipeg.

Mr. Millican will represent Blue Cross Plan District XII which comprises all of Canada. He has had lengthy and broad experience in the non-profit prepayment field in Canada, becoming Associate Director of Manitoba Hospital Service Association in December, 1938, and later, that Plan's Executive Director. He was given a leave of absence in August, 1941, to conduct a survey and advise regarding formation of a hospital service plan for Quebec, and, in October, 1941, became the Executive Director of the Quebec Plan.

Mr. Millican was previously a member of the Blue Cross Commission, having served as District XII Commissioner from December, 1946, to April, 1952.

Minerva E. Reid

Dr. Minerva E. Reid, one of Toronto's outstanding woman doctors, died in April at her home where she had practised for more than 40 years. Born in Orangeville, she graduated from the University of Toronto in 1905 and took over the practice of her brother at Tillsonburg. In 1911, she went to study in London where she became a member of the Royal College of Surgeons and in Dublin where she became a Dublin Licentiate in Medicine.

During the First World War she served as assistant to the late Dr. F. N. G. Starr, and from 1915 to 1925, demonstrated her ability as one of the leading members of her profession as the chief surgeon at the Women's College Hospital, Toronto. Despite the demands on her time she moved into the field of civic government, serving from 1926 to 1932 as a member of the Board of Education.

Her retirement from the active staff of the Women's College Hospital in 1938 left her few idle moments. As well as continuing with

a large private practice until two years ago, she retained a lively interest in civic affairs and among other things, spearheaded a national drive supporting demands for the immediate erection of Sunnybrook Hospital in 1944.

Newly-elected Chairmen of Hospital Boards

Among those recently elected president of hospital boards are: A. P. Tracy-Gould, Miramichi Hos-

pital, Newcastle, and Judge Adrien Cormier, Hotel Dieu, Moncton, N.B.; William Harkness, Maple Ridge Hospital, Haney, B.C.; R. A. H. Taylor, New Liskeard and District Hospital, New Liskeard, Maurice K. Humpage, War Memorial Hospital, Dunnville, John Murie, McKellar General Hospital, Fort William, and R. D. Parker, Sudbury Memorial Hospital, Sudbury, Ontario.

Presidents of Medical Boards Recently Appointed

Newly-elected presidents of medical boards include Dr. J.-Alcide Martel, Ste-Justine Hospital, Montreal, and Dr. Marcel Fortier, Hôpital du Sacré Coeur, Cartierville, P.Q.

(continued on page 22)



Muscular Dystrophy Research

When Dr. Eors Bajusz (second from left) joined the "Freedom Fighters" of his native Hungary last October, he little dreamed that in three months he would be in the forefront of the fight against muscular dystrophy in the western world. A chance meeting with Dr. Hans Selye (left) of the University of Montreal, Montreal, P.Q., brought him in contact with Arthur Minden, lawyer of Toronto, Ont., and president of The Muscular Dystrophy Association of Canada (third from left) and Dr. David Green, Toronto, 1st vice-president (on the right). When the four met in Montreal recently, The Muscular Dystrophy Association awarded a research grant to Dr. Bajusz for one year to study the effects of hormones on mice that have inherited muscular dystrophy—like the one he is holding.

Scientists at the Roscoe B. Jackson Memorial Laboratory at Bar Harbour, Maine, last year succeeded in breeding a strain of mice that genetically trans-

mit muscular dystrophy. This was a great step forward in research work, and now Dr. Bajusz, having so recently completed two years' work at the Institute for Muscle Research in Budapest, can use some of these mice to try to find out whether hormones are effective in the treatment of muscular dystrophy. As far as is known, this will be the first systematic work carried on in this field and Dr. Selye hopes the experiment may provide a clue that could lead to a cure.

Dr. Bajusz, son of a medical practitioner in Hungary, was graduated from the University of Budapest with the degree of M.D. in 1950, and went immediately into research work until the revolution last year put a temporary halt to his work. Now, with the help of The Muscular Dystrophy Association of Canada, he is happily carrying on in his adopted country . . . with facilities and equipment he could not have had in Hungary.

Muscular Dystrophy Assoc. of Can.



Until recently, very few in the profession questioned the adequacy of plaster of Paris bandages. It was felt that these bandages were satisfactory in most respects.

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Notes About People
(continued from page 12)

Four Section Heads Appointed

Four new services have been created in the department of surgery at Victoria Hospital, London, Ont., and four members of the surgical staff have been appointed to head them. Dr. A. J. Grace, associate professor of surgery, will be in charge of the thoracic service; Dr. J. C. Kennedy will direct the orthopaedic service and is promoted from senior associate to assistant professor of surgery; Dr. C. G. Drake will direct neurosurgery and is promoted from senior associate to assistant professor; and Dr. L. N. McAninch will be in charge of the genito-urinary section and is promoted from instructor to assistant professor.

New Appointment
to O.H.A. Executive

Harold G. Dillon has recently undertaken his duties as executive assistant to Stanley W. Martin, executive secretary-treasurer, of the Ontario Hospital Association.

Born in Collingwood, Ontario,



Harold G. Dillon

Mr. Dillon served with the Royal Canadian Air Force from 1941 to 1946. In 1950, he graduated from the University of Western Ontario with the degree of Bachelor of Arts in business administration. After graduation, he enrolled in the course in hospital administration at the University of Toronto, and served his administrative residency at Victoria Hospital in London, Ontario.

From 1952 until 1955 Mr. Dillon was closely associated with the development of the C.H.A. extension course in hospital organization and management through his capacity as administrative assistant on the staff of the Canadian Hospital Association. In 1955 he was appointed as research fellow on the faculty of the Department of Hospital Administration, School of Hygiene, at the University of Toronto. In this position Mr. Dillon directed the two-year program of research known as Practical Studies in Education for Hospital Administration.

In announcing the appointment, C. V. Charters, president of the O.H.A., stated that the addition of Mr. Dillon to the staff would enable the Association to meet more fully the increasing appeals for assistance made by the member hospitals and facilitate greater service in several areas of hospital administration presently under study.

Newly-Appointed Pathologist

Dr. H. G. U. Danziger has been appointed as pathologist to succeed
(continued on page 28)

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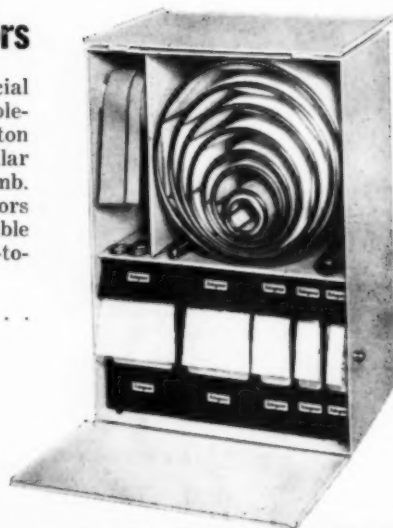
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Notes About People
(continued from page 22)

Dr. Grant Colpitts at the Welland County General Hospital, Welland, Ontario. The new member of the staff holds a certificate in pathology from the Royal College of Physicians and Surgeons. He has practised medicine and pathology in Germany and China and was previously on the staff of the Central Laboratory of Pathology of the provincial government in Toronto.

Medical Director Appointed at Misericordia General Hospital

The appointment of Dr. John Noel Roberts Scatliff as Medical Director of Misericordia General Hospital, Winnipeg, was recently announced. He assumed his duties as of June 1st.

Born in Brighton, England, in 1903, Dr. Scatliff graduated from St. Bartholemew's Hospital, London, in 1941. Following internship in England, Dr. Scatliff carried on general practice until 1948 when he migrated to Canada where he again took up practice at Argyll, Manitoba. In 1950 Dr. Scatliff attended the University of Toronto and,

upon acquiring his Diploma of Public Health, he returned to Western Canada to administer the Red River Health Unit of the Manitoba Health Plan until 1954. He



John Noel Roberts Scatliff, M.D.

was then transferred to administer the St. Boniface Health Unit until moving again to manage the St.

James-St. Vital-Fort Garry-Charleswood Unit in which he has been engaged until his present position.

Dr. Scatliff's appointment at Misericordia General Hospital fills the vacancy left by the death of Dr. Owen C. Trainor in November of last year.

Director of Pilot Project Appointed

The Canadian Nurses' Association has announced the appointment of Helen K. Mussallem to the staff of the National Office as Director of the Pilot Project for Evaluation of Schools of Nursing in Canada. This project was the subject of an article by Frances McQuarrie, Nursing Education Secretary of the C.N.A., which was published in the April issue of *Canadian Hospital*.

Miss Mussallem is a graduate of the Vancouver General Hospital School of Nursing and holds a B.N. degree from McGill University and an M.A. degree from Columbia University. Her experience has included positions as staff, operating room and head nurse, and supervisor at the Vancouver General

(continued on page 102)

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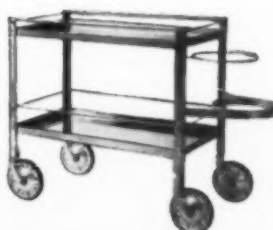
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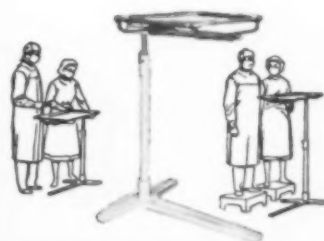
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56-52



Obiter Dicta

New Concepts in Child Care

A VISION of more than fifty years' standing became a reality on the morning of Sunday, December 9, 1956, when patients and staff of the Montreal Children's Hospital moved into the impressive new \$10,750,000 buildings at Atwater and Tupper Streets in downtown Montreal.

The move marked the realization of a dream that had its origin in 1902. In that year the late Alex MacKenzie Forbes, then Professor of Orthopaedics at McGill University, envisaged a separate hospital for the care of infants and children, an institution that would some day become a complete health and medical centre.

The new hospital is indeed a complete centre from basement to thirteenth storey. It is equipped with every facility necessary for modern patient care and rehabilitation, paediatric education, and research in childhood injury, illness, and disease. The hospital embodies new concepts in child care.

Financing of the present up-to-date plant was accomplished largely through the hospital's participation in Montreal's Joint Hospital Funds of 1950, 1953 and 1955-56. The hospital stands, therefore, as a tribute to the generosity and support of thousands of Montreal corporations and business firms, individuals, and governments at all levels.

A series of articles, prepared especially for this issue of *The Canadian Hospital*, portrays some of the more unusual features and services of the new Montreal Children's Hospital.

We wish to acknowledge here the willing co-operation of Dr. Herbert Owen, assistant director of the hospital, who arranged for the preparation of this symposium. The individual authors also merit our thanks for their contributions.

Traduction

Un rêve âgé de cinquante ans ou plus s'est réalisé le matin du dimanche, 9 décembre 1956. Les patients et le personnel du Montreal Children's Hospital déménagèrent ce jour-là pour occuper les nouveaux bâtiments imposants, construits au coût de \$10,750,000 et situés sur les rues Atwater et Tupper dans la ville de Montréal.

Le déménagement marqua l'accomplissement d'un rêve qui est né en 1902. Cette année-là feu Alex Mac-

Kenzie Forbes, professeur d'orthopédie de ce temps-là à l'Université McGill, caressa le rêve d'un hôpital à part destiné au soin de bébés et d'enfants—institution qui servirait un jour comme centre médical et thérapeutique indépendant.

Le nouvel hôpital est, en effet, un centre indépendant y inclus le sous-sol jusqu'au treizième étage. Il renferme toute facilité nécessaire pour le soin moderne des malades et leur réhabilitation, pour l'éducation en pédiatrie, les recherches sur les accidents d'enfance, et toute sorte de maladie. L'hôpital met en application les plus nouveaux concepts du soin d'enfants.

Le financement de cette institution moderne a été accompli en grande partie grâce à la participation de l'hôpital dans les Joint Hospital Funds de Montréal en 1950, 1953, et 1955-56. Aujourd'hui, donc, l'hôpital signifie un tribut à la générosité et à l'appui prêté par des milliers de corporations et maisons de commerce montréalaises, des individus, et les gouvernements à chaque niveau.

Une série d'articles, préparés spécialement pour ce numéro de *The Canadian Hospital*, montre quelques-uns des services et des aspects les plus frappants du nouveau Montreal Children's Hospital.

Nous voulons souligner ici la coopération bienveillante du docteur Herbert Owen, sous-directeur de l'hôpital, qui dirigea la préparation de ce recueil d'articles. Les auteurs individuels méritent aussi nos sincères remerciements.

In-Service Educational Programs

THE PRINCIPLE of in-service education is a simple one. It is some definite program by which the people who are employed in a hospital may learn more about their own jobs and the relationship of their work to that of others employed in the hospital. It is a means by which to discover methods and ideas which will make a position not only more meaningful but aid one in the performance of it with a higher degree of efficiency and thoroughness. The principle applies not only to those who have not had the advantage of formal training for their particular field of employment; not only to those who supervise a number of employees; nor to those who work in a large hospital with its complex organization. Every hospital

has the resources by which a worth-while program can be developed; every individual employee can benefit from a better appreciation of his rôle and that of his or her co-workers in the function of providing the best possible care to the patient. The benefits are many—they mean a more efficient employee who fulfils his or her work for the greater comfort and welfare of the patient, a better liaison with other workers and departments, a more complete enjoyment of his work. This all results in an increased satisfaction to the administrator. A happy employee is the best long-service investment you can make.

What type of program should be carried out and when should it start? Why not begin at the time of employment? The word "orientation" should not frighten you. It simply means that each new employee is met courteously on the first day of work and is given a thorough and pleasant introduction to the hospital as a whole, to the fellow employees with whom he or she will come into contact and, of course, to all the aspects of the job. It will absorb some working time during the first few days of employment, not only for the new employee, but for the persons responsible for the orientation program; the rewards will come later. This is what you yourself would expect, or at least want, as a new employee. Why should others not receive it?

In-service educational programs fall into two main types, those for supervisors and those which teach the individual a specific skill or the best method of performing his or her job. The latter may be, even more than the former, a mixture of training and education—training in that they teach a particular work habit or procedure, and education in that they should also incorporate some broader understanding of the individual's rôle in the hospital and import some familiarity with the policies and opportunities which exist in that department and in the hospital as a whole.

A program of continuing education for supervisors is vitally important because few people excel naturally in this capacity. This fact is particularly apparent in the hospital where so many people trained in specialized skills are given tasks of supervision which they are expected to perform without the benefit of specific guidance in such techniques. We all know that the best bedside nurse is often the one who is placed at the desk as head nurse. Here she is suddenly required to do a job of supervision which is quite apart from her experience and, very often, her inclination or ability. She, just as much as the recently-acquired department head in the laboratory, laundry, or dietary department, needs a course in supervisory principles and techniques. She also needs the same type of introduction to the policies and routines which operate in the other departments with which she must co-operate. This is required if the entire organizational pattern of the hospital is to function to the greatest degree of efficiency and satisfaction.

Who will do the teaching? Why not do it yourself, in co-operation with the other senior members of the hospital? Nearly all supervisors and most senior employees have a fund of knowledge which, with some organization of ideas and some encouragement, could be imparted with interest to others in the hospital. It is amazing how a request to give a lecture brings out the best in a person and, as a helpful corollary, gives one a better appreciation of the job he performs each day and its possibilities. Use outside speakers and demonstrators if they are available and the subject matter is of use. It is true that you can't teach the principles of supervision if you don't know

them. If you do not, it is time that you did some reading, made some notes, and an analysis of your ideas in comparison with those of others. Managers and personnel officers from nearby industries may be happy to speak or to lend you a speaker for a few sessions. Vocational schools and universities offer a fund of courses, facilities, and lecturers which should be exploited and used if applicable to your needs. Graduates of courses in hospital or business administration should be able to organize their notes and experience to provide some useful lecture material. Present the problem to the people you know and consider to be "enlightened"; some of them will have ideas which when developed, will prove to be of value.

There are many approaches to the content of any course. Try the use of some case problems for discussion (preferably ones which are not derived from the experience of those present) and discover how your ideas vary from those of the others in attendance. Obtain manuals on job instruction to use as guides. Attend institutes, conventions and workshops when feasible and arrange to have other staff members do likewise. Above all try to use the people who are readily available to you, especially those in your own hospital. If the speaker is dull or the subject and presentation are lacking in interest, the program will falter and probably fail. But—given a show of enthusiasm, sound ideas, encouragement, and proper direction, there is no good reason why a worth-while in-service educational program of a very real value cannot be developed by any hospital, be it 20 beds or 2,000, half-full or overcrowded. This is true in any location between Newfoundland and British Columbia, the 49th parallel and the Arctic Circle.

—R. J. C. McQueen.

National Water Safety Week

THE WEEK of June 16 to 22, has been proclaimed National Water Safety Week by the Canadian Red Cross Society. It is the hope of the Society that publicity during this week will enlighten our citizens concerning the annual drowning toll and the dangers that lurk in, near, or on the water surface.

Canada is a vast playground of lakes, rivers, and streams and only a knowledge of water safety will curtail the number of drownings which turn summertime and funtime into a season of sadness and tragedy for many of our neighbours.

A knowledge of water safety rules and a bit of common sense will save lives this summer. The Red Cross warns that a large percentage of drownings can be traced to accidents among children, but also points out that almost 25 per cent of the drownings in Canada are those of people in the age group between twenty and thirty.

Water safety should be the concern of every Canadian. Only a nation-wide, concerted effort will reduce the toll. Tragic headlines seem to be forgotten in a very short time. It is the responsibility of all of us to curb the carelessness of people when they are in, near, or on the water.

We hope the efforts by the Canadian Red Cross during the Water Safety Week will awaken in every one of us, a sense of responsibility. It is our hope that the statistics available when the season ends will give us a great reduction in the number of deaths caused by neglect of water safety rules. This summer, enjoy the great outdoors—drive carefully, swim safely and enjoy living.



MONTREAL CHILDREN'S



THE MONTREAL Children's Hospital is one of the very few medical centres in Canada devoted exclusively to the study, treatment and prevention of diseases in infants and children. It is a teaching hospital for McGill University. For many years this hospital had been severely handicapped in its work because of exceedingly inadequate and somewhat inaccessible quarters—until the month of December, 1956, when the new Montreal Children's Hospital opened its doors for patients.

This new hospital has a total floor area of over 400,000 square feet and a bed capacity of about 400, including accommodation for adolescent children, private patients, mothers of patients and patients whose condition requires that they be kept in isolation during part or all of their hospitalization.

Children with all types of medical, surgical or special conditions are studied and treated at the hospital, with the exception of uncomplicated cases of active pulmonary tuberculosis or certain of the contagious diseases.

Investigation and treatment services have been provided for clinical, educational and research purposes. While it is true that clinical and scientific research was being undertaken in the old hospital, research programs are being established on an expanding basis and our Department of Experimental Paediatrics has the official recognition of the federal and provincial governments.

The subjects of the following articles have been chosen to illustrate the complex structure required by a medical centre for infants and children. In this

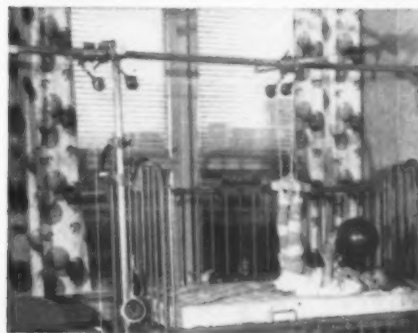
HOSPITAL

hospital lay-out
the rôle of colour
nursing program
research activities
physiotherapy
occupational therapy
mental assessment
group guidance
speech clinic
out-patient department
grade school
social service
food service

hospital medicine, surgery and their clinical sub-departments, anaesthesiology, bacteriology, biochemistry, and all other departments are as highly developed as in a teaching hospital for adults. The professional staff of these departments are not only qualified in their respective specialty but in addition are experienced in working with infants and children.

Finally, the Montreal Children's Hospital is a well developed, progressive centre for rehabilitation of infants and children with emotional and/or physical handicaps and is recognized by both the Department of National Health and Welfare and the Quebec Ministry of Health as one of the leading centres for handicapped children for the Province of Quebec.

—J. E. de Belle, M.D., C.M., F.A.C.H.A., Executive Director.





hospital lay-out

WHILE the new location of the Montreal Children's Hospital may lack the picturesque aspects of the former site on the mountainside, it has many compensations, as well as advantages. By no means the least of these is its proximity to Montreal's midtown civic bus terminal—which provides ready transportation to all parts of the city. At the same time the additional facilities for treatment, together with the increased accommodation for patients, now brings the hospital into an excellent position in relation to other local institutions.

In this series the names of authors appear at the end of each section.

The new additions have been built around the original private patient's pavilion of the old Montreal General Hospital and the irregular site occupies an entire city block. The remodelled building is ten storeys high and the new wing on Essex Street runs to 13 storeys with provision for future extensions.

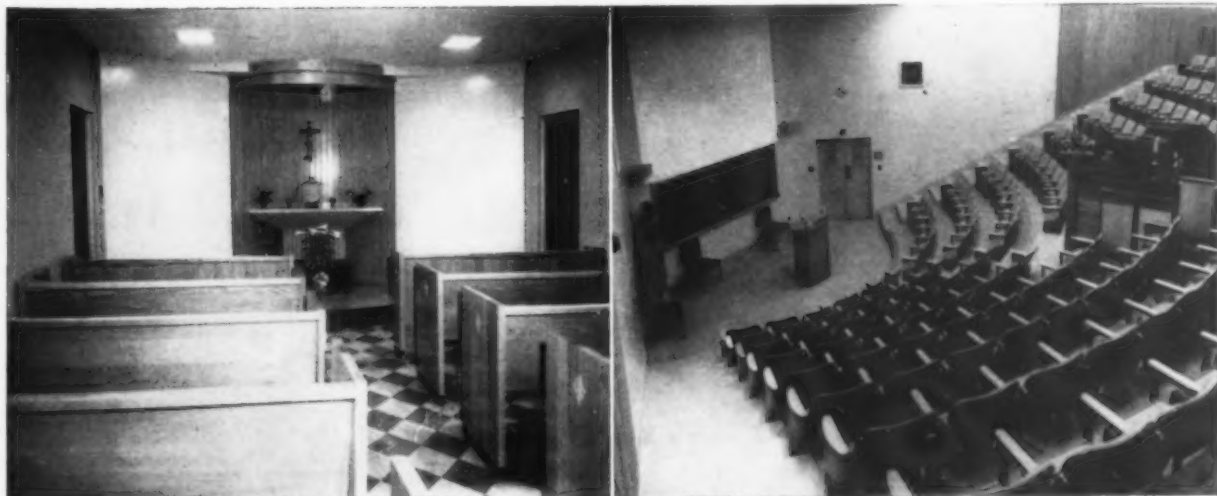
The tower which dominates the group contains the air-conditioning equipment and new elevator machinery. The hospital now has a bed capacity of 401, of which 385 beds are available for in-patients of all classes; the remaining 16 beds are reserved for post-operative, recovery, isolation and emergency cases. This new bed capacity is more than twice that of the old hospital which

had 173 beds. The largest wards contain six infants' beds and the others are four-, two-, and one-bed units.

The basement contains a more or less unique feature in the form of a chapel with a revolving altar, arranged to meet the needs of three religious denominations. Other divisions in this area include space for medical records, pharmacy, central supplies and staff locker rooms.

Situated on the ground floor at the corner of Essex and Tupper Streets is the main entrance, convenient to the general administration and executive offices, the accounting and purchasing departments, admitting and registration; as well as a gift shop and snack bar, both operated by the Women's Auxiliary. The out-patients' and ambulance entrances are also located at this floor level on Dorchester Street. Adjacent to the main entrance is an amphitheatre, seating 173 persons, completely air-conditioned and wired for closed-circuit colour television.

The second floor is largely an extension of the out-patients' department—containing minor surgery, fracture room, dental surgery with treatment rooms, an 8-bed recovery ward, and 20 medical examining rooms, with nine others for surgical cases. The social service department, eye clinic, and a large gymnasium for physiotherapy also are located here in conjunction with the out-patients' department.



Left: chapel has revolving altar for three faiths; right: amphitheatre with fine acoustic facilities seats 173 persons.



*Formal reception room
in nurses' residence*

Radiology occupies the major portion of the third floor and includes six diagnostic and two therapy rooms. One of the features in this group is the high-voltage radiograph and fluoroscopic room which, besides providing for normal usages, also presents an opportunity for treating patients under anaesthetic agents. It is used during many highly technical diagnostic proceedings such as catheterizations, angiograms, bronchograms and pneumograms. Also located on this floor are the departments of occupational and physical therapy, medical genetics and cardiology.

Features on the fourth floor include pathology, biochemistry, electro-encephalography, haematology and allergy laboratories, photography, medical teaching facilities, library, museum, conference room, class and seminar rooms and a common room for medical students.

The fifth floor is the first level on which in-patients are accommodated and contains space for 28 younger patients. In addition are the departments of psychiatry, speech therapy, school studies, rehabilitation and group guidance. The sixth to ninth floors are almost entirely devoted to in-patients with the usual services. On the eighth floor there is a screened outdoor play area.

The entire tenth floor is occupied by the department of surgery and

includes seven ultra-modern and fully equipped operating rooms. One of these has a viewing gallery and another is wired for television with an adjoining television control room for transmission to the main floor amphitheatre, as well as the fourth floor class rooms. A fracture room, cystoscopy room, and the usual facilities for sterilizing, instrument and linen storage, are located in conjunction with the various suites. The offices of the department of anaesthesia, the tissue laboratory, and induction rooms also are on this floor. The latter rooms are decorated with unusual murals.

Doctors' offices, and a lounge and lockers for special duty nurses, occupy the eleventh floor. On the twelfth floor is a day centre for the rehabilitation of emotionally handicapped children, including classrooms and a nursery school. Endocrinology and isotope laboratories are located here in conjunction with the foregoing facilities. On the thirteenth floor of the new wing are the bacteriological laboratories and animal quarters.

Located in the centre of the group of buildings is the service block (see plan) comprising the heating plant, kitchen stores, central linen, laundry and workshops on the lower floors, with the main kitchen, cafeterias and dining rooms on the upper floors. This block serves the adjoining wings by means of bridges at the various floor levels.

Facing Dorchester Street, the former nurses' home has been completely renovated providing quarters for interns and residents. Opposite the new wing on Essex Street, and connected by a tunnel to the hospital, is a new eight-storey nurses' residence containing 138 single rooms. At present the seventh floor of the new residence remains unfinished. It will ultimately provide classrooms and accommodation for an additional 24 nurses.

Architecturally, no attempt has been made to follow the original lines of the older building which was designed solely for private patients, based on the two-room unit with a bathroom between. In the interests of economy, the new portions have been treated in a simple manner, common brick, wood sash covered with stainless steel, and a limited amount of stone work forming a base for the ensemble.

—McDougall, Smith and Fleming,
Architects, Montreal, P.Q.



Mural portraying colourful circus attracts small patient.

the rôle of colour

ABOUT a week after the new buildings of the Montreal Children's Hospital were opened, a young patient on leaving the hospital was heard to remark: "This sure is a beautiful place; I wouldn't mind coming back anytime!"

The fervour and sincerity of the youngster's comments are warm praise for the efforts and imagination of a Montreal woman by the name of Mary MacMillan, whose knowledge of the new hospital buildings is only slightly less than that of the architects. Mrs. MacMillan, well-known decorator and colour consultant, was called upon some three years ago, when the new hospital buildings were still in the blueprint stage.

It should be noted here that blueprints are no mystery to Mrs. MacMillan, whose formal education includes an engineering degree. But it is one thing to read blueprints and another one to be able to translate them into fully furnished and colourful rooms serving a multiplicity of purposes. One basic rule, of course, is that in no area should a children's hospital look like a hospital; or at least like the cold and

sterile hospital that children so often fear.

"Hospital decorating", says Mrs. MacMillan, "differs greatly from general commercial or household decorating. Initially, many months of research are required; colours and furnishings must be assessed in terms of the purposes for which areas will be used. This is particularly so in a children's hospital, where even the age of patients is an important factor in the décor."

The Montreal Children's Hospital is a cheerful, even happy place. Much credit for this goes, of course, to the staff, known and remembered by children for their kindness and understanding; but a full share of credit for making the hospital cheerful and gay goes to the decorator. Floors and furniture, curtains and ceilings, walls and even equipment reflect her efforts. It is impossible to portray, in few words, the décor of the new Montreal Children's Hospital; but there are highlights.

Colour predominates, certainly. Sunny yellows, bright greens, blues, and pastel pinks fill rooms and wards. Curtains in younger

patients' rooms depict nursery rhymes and circus scenes; for teen-agers, modernistic designs attract attention. Throughout the hospital, the various colour combinations are functional. They shorten corridors, raise and lower ceilings, offset the glare of morning sunshine and capture the warmth of the afternoon's rays. They create illusions, convey happy moods and focus attention. In many cases they actually serve to guide parents and visitors to destinations within the 13-storey hospital.

The decorator's colours are bright. And why not? "Children love bright colours," she points out. But merely choosing bright colours was not the extent of Mary MacMillan's job. As the new Montreal Children's Hospital includes both new and renovated buildings, one of the resultant tasks was to correlate colours in the old and new buildings so as to make it virtually impossible to distinguish old from new. Wood throughout the hospital is finished in a soft buff colour and both new and "reclaimed" equipment match room colours.

In the case of new equipment—and almost everything in the hospital is new—this latter feat was accomplished by the decorator's specifications for colours, even tones, when equipment was ordered. In radiology, for example, the deep, soft green of the walls is matched exactly by the baked enamel finish of the x-ray equipment.

Long before the first brush was dipped into a paint can, Mrs. MacMillan discussed colours with department heads, who were asked their preferences among those colours suitable for their areas. Surgery, for instance, was given three colour choices: grey, aquamarine, and several darker shades of green. Grey was chosen both for tiles and enamel; all finishes are matt.

In some areas, colours were selected not for what they would do but for what they would *not* do; e.g., in the recovery rooms, blues and yellows were regarded as unsuitable because they tend to produce unnatural colouring on patient's faces. Flesh tones were chosen.

In patients' and waiting rooms throughout the hospital, the colour scheme has generally followed the principle of correlating three walls of one colour with a fourth wall in a second. In larger rooms with columns, the latter are usually in a third colour. In some areas, fourth and even fifth colours have been introduced in drapes, floors and furniture. The hospital's large gymnasium—part of the physiotherapy department—features one wall in bright yellow and the others in turquoise. The colourful linoleum floor has, inset, a seven-foot-wide strip of yellow with little black footprints set into the yellow strip. The footprints are highly amusing to children—but guide them to better posture and in towards learning to walk again.

One of the most colourful areas is the large out-patient department waiting room, which seats over 200 persons. Three walls are in sunshine yellow, with the fourth wall peacock blue; columns are in coral. Unusual effects have been created in younger children's play areas—inset in the floors, and thus surrounding the children and seemingly playing with them, are bunny rabbits carrying books, going to school, and falling asleep.

Among the most commented-upon features of the hospital's décor is the art work. Done voluntarily, and donated to the hospital, it truly is outstanding.



Dental surgery features wall and ceiling cut-outs.

On the tenth floor, in a pre-operative waiting area, one entire wall is covered with a mural of gnome-like imps engaged in humorous activities. "Oh, look at the funny little men!" exclaim children on entering the room—and their thoughts are of the gnomes rather than of themselves. The mural is the work of Lawrence Batchelor, Montreal.

Three eight-foot murals by Mrs. Bruce Ruddick of Montreal have won wide acclaim. The murals portray zoo, farm, and circus scenes. One is in a corridor used by ambulatory patients and the other two are in public wards.

The ophthalmology waiting room features paintings by William Taylor, Montreal, of a clown with a black patch over one eye, a duck wearing horn-rimmed spectacles and a monkey admiring his new glasses in a mirror.

In the dental surgery waiting room is a frieze portraying Christopher Robin and his Winnie-the-Pooh pals, the work of Thurstan Topham, A.R.C.A. Curtains in the room narrate the happy tale of the owl and the pussy cat. In the dental surgery itself, where walls are tiled from floor to ceiling and where patients are on their backs while under local anaesthetic, cut-outs on the ceiling show a teddy bear, wearing a dressing gown and brushing his teeth, and also a group

of "cowchildren" lassoing calves. The cheerful cut-outs are the work of George Zylinsky, whose cut-out creations are widely known through Quebec and Ontario.

Mr. Zylinsky has also contributed cut-outs of farm people, buildings, and equipment, for the radiology waiting room; Snow White and the seven dwarfs for the group guidance department; and children in folk costumes of many lands for the out-patient department.

A point of discussion are the gay scenes in the out-patient department waiting room, depicting the calendar months, and painted by the Montreal artist, Primavesi. He has painted as children themselves paint—in two dimensions and with free use of colour. Adults are perplexed; children are delighted. And, as Mary MacMillan emphasizes, "it is a children's hospital".

Mention is made of the amphitheatre, cafeteria, and new residence for nurses. The amphitheatre is an architectural achievement in terms of both design and acoustics; the design suggests a much larger amphitheatre than the cubic footage indicates. Walls are green, tiers and chairs are cocoa and buff, and stairs are green-and-cream terrazzo—so that those arriving late or departing early can see the stairs in the dark.

The cafeteria is strictly non-hospital; it suggests, rather, the

dining room of a private club. Colours are satinwood and two shades of green. Chairs are of birch, finished in a mahogany shade, with leather seats in either green or satinwood. Tables have mahogany - finished injury - proof tops.

The eight-storey, 162-room nurses' residence features single rooms with built-in furniture, including chests, desks, beds, closets, mirrors. Pull drapes match wall colours and lighting fixtures are modernistic in design. Each floor features a communal sitting room with adjoining kitchenette. On the main floor are informal "date rooms", and rum-pus and games rooms are in the basement.

Outstanding is the formal reception area on the main floor of the residence. Measuring approximately 45 by 60 feet, the room has two central columns. Judicious placing of chesterfields and lounges makes the columns part of the room. Décor includes replicas of period furniture in mahogany and two magnificent oil paintings, given to the hospital some years ago. Room colours were selected to complement the oil paintings: aquamarine walls, rose spice carpeting, chocolate upholstery, and effective use of gold, aquamarine and coral throughout the room.

Assisting Mrs. MacMillan in the décor of the nurses' residence were Dora Parry, R.N., director of nursing and Mrs. John H. Molson, Mrs. F. M. Woolhouse, and Mrs. Dent Harrison, members of the Women's Auxiliary.

In all, the new Montreal Children's Hospital incorporates about 35 colours and tones. Paints were mixed under the decorator's personal direction in the laboratories of a national paint manufacturer and samples, properly labelled, have been given to the hospital. For maintenance purposes, any quantity of any colour or shade can be ordered directly from the manufacturer. In addition, Mrs. MacMillan has provided the hospital with a master reference and guide book, giving details of the furnishings in every room and area and including colour and material samples and swatches.

"Where many colours are used, maintenance questions do arise", says Mrs. MacMillan. "The reference book and samples make maintenance easy".—Donald J. Duff—based on an interview with Mrs. Mary MacMillan, Montreal, decorator and colour consultant.



Dr. John E. de Belle, (right) executive director of the hospital, Dr. Alan D. Ross, (left) physician-in-chief, and John H. Molson, (centre) hospital president, endeavour to coax smile from small patient.

nursing program

THE SCHOOL of Nursing of the Montreal Children's Hospital is an affiliate school giving a 12-week course in basic paediatric nursing to student and post-graduate nurses. Approximately 300 students per year affiliate from 18 schools of nursing, located in Quebec, Ontario, New Brunswick, Bermuda, and Vermont, U.S.A. The McGill School for Graduate Nurses sends students taking "Teaching and Supervision in Maternal and Child Health" for their field work. The primary purpose of the Montreal Children's Hospital is the total care of the child—to tend his physical, emotional and social needs. To realize this aim, focus is centred on the child and every effort is made by each member of the hospital staff to give the young patients a feeling of security.

The student nurse also requires this sense of security if she is to give the best in total patient care and gain an all-around knowledge of paediatric nursing. She must have the technical knowledge of treatments and techniques, be able to recognize and interpret symptoms, and contribute to the needs of

the unhappy lonesome child suffering from maternal deprivation. During the weeks the student is affiliating, she receives many hours of teaching in child care and development, in many and varied diseases of childhood, and in the hereditary diseases and congenital anomalies. She receives instruction in play and attends bedside clinics and ward teaching sessions. There are group conferences in which she participates as a member of a group of co-workers, consisting of the chief of the service, medical social worker, physiotherapist, occupational therapist, school teacher, group guidance director, psychologist and psychiatrist. Topics discussed cover a wide range and give the student knowledge and insight toward a better understanding of herself, the parent and the child.

Over the years our understanding of the parent has undergone radical change. Gone are the days when the mother and father were banished with all possible speed from the ward, when the child was admitted to the hospital and visiting day brought parents for one hour every second Sunday. This was stoically endured, with the result that many small infants and



Recovery ward



Nursing station



Nurse's bedroom

children tended to be overwhelmed by the experience and clung to the familiar figure in white for security. At present the parents are encouraged to visit their children daily, visiting hours being 2:30 to 6:30 p.m.

However, visiting rules are very flexible, and the head nurse endeavours to arrange other periods for the convenience of the parent or

the need of a particular child. In the new hospital, a ward comprising nine two-bed rooms has been provided to enable parents to remain with their children for the entire hospitalization period. It is felt that in the case of young children, the presence of the mother eliminates much of the psychological trauma suffered in the past by this age group.

More and more we are striving toward the happy, relaxed child in an institution geared to his total well-being. There is a great demand for the nurse who understands the care of children and their diseases, and few children's hospitals give the three-year course at present. Therefore, it is of the utmost importance that the affiliate student receive all the help, understanding and knowledge we can help her to achieve, so that she may give the best care to the child.

Since the School of Nursing trains affiliates only, the nursing staff is made up of graduate nurses from many different training schools, and an active and well-organized staff nurses' association has become a necessity. This is an organization with a constitution, an executive of elected members and a membership of staff nurses, including the director of nursing.

The group guidance department, established in 1951, participates in the nursing education program as well as serving the social-emotional welfare of patients in the hospital. The nursing department and group guidance department have always worked closely together in efforts to teach and provide comprehensive treatment and care for the children.—H. Nuttall, R.N., Assistant Director.

research activities

IN ORDER that a children's hospital may function as a true medical centre for children, it is essential that an active program of medical research should be carried on. Such a hospital cannot be satisfied with merely utilizing the advances made and experiences gained in other institutions. In addition, the basic body processes of health and disease must be constantly investigated, new and improved treatments must be devised and evaluated, and the results of such studies reported periodically in the medical literature.

The administration of the Montreal Children's Hospital has long been keenly aware of the need for expansion of the research program. As a result, the new building provides greatly increased space for research laboratories and a general research endowment fund is being developed to support present and future projects. A brief outline of a few of the studies now being carried out will give some idea of the scope of this program.

The department of medical gen-

etics, under the direction of Dr. F. C. Fraser, is conducting a long-term study of the hereditary aspects of convulsions in children. This department is also investigating the experimental production of congenital abnormalities in laboratory animals. It has been possible to produce consistently such congenital defects as cleft palate in animals; and it is hoped that these experiments will lead to a better understanding of the mechanism of their occurrence in man.

In the department of cardiology, Drs. Paul Sekelj and W. Jegier are developing a rapid method for the determination of blood volume and of cardiac output. The results of these tests are rapidly calculated by an electronic computer and are, thereby, immediately available as an aid in the diagnosis of congenital cardiac defects. This project is being done with the co-operation of the department of physiology at McGill University.

In the same department, Dr. Arnold Johnson and his staff are conducting long-term studies on the prevention of recurrences of rheumatic fever, and these studies are yielding information of great practical value in the handling of children afflicted with this disease.

Dr. Frances McCall, director of the department of endocrinology, is investigating the levels of adrenal hormones in the blood and urine in a wide variety of disease states. A laboratory for experimental endocrinology has been established, under the direction of Dr. Claude Giroud. Here, the extraction of individual hormones from the adrenal glands is being performed, and the results of these studies are expected to throw additional light on the functioning of this vital and complicated organ.

Drs. Ronald Denton and Robert Gourdeau have begun a large-scale evaluation of the factors responsible for the clotting of blood in newborn infants. This is one of the most comprehensive studies of its kind which has been attempted to date, and may improve our understanding of bleeding disorders in this age group. Experiments with the use of new techniques in cardiac surgery, with special reference to "open heart" methods, are being done continually, by the department of cardiovascular surgery. This department is under the direction of Drs. David Murphy and Gordon Karn, who, for several years, have maintained an ever-expanding program for the surgical

correction of congenital heart defects.

Drs. Richard Goldbloom and J. E. Richards are investigating the physiology of vitamin E in newborn infants. Another study centres on the importance of levels of blood calcium in the development and prevention of occlusions in infancy, and the influence of such levels on the electroencephalogram. This study is under the direction of Drs. R. Goldbloom and S. Fyles.

Dr. Eleanor Harpur and Ann Henry in the department of biochemistry are studying the alterations in blood proteins in many diseases, by the technique of electrophoretic protein fractionation.

The above represents only a partial listing of the subjects presently under investigation. Other problems are under study in the departments of allergy, psychiatry, and surgery. However, this summary serves to give an idea of the scope of the work being done. The overall research plan at the Montreal Children's Hospital is one of continuing expansion—it is felt that only in this way can the highest standards of medical care be maintained and advanced.—*Richard Goldbloom, M.D.*

mental guidance clinic

MENTAL retardation is an affliction which touches some three per cent of our school children. Within recent years the public has become very much aware of the seriousness of this problem and its terrible cost—in both human and economic terms—to affected families and to the community of which they form a part. With better understanding, the savage concept of the retarded person as a sub-human being is giving way to the realization that like the deaf, the blind, and the crippled, he is a handicapped person who deserves similar

consideration, and who deserves whatever help can be given him to make his existence as fruitful as possible for himself and the people among whom he must live.

With the quickening change in public feeling in the matter, there has been developing professional interest in the problems of retardation. The older pessimistic view of retardation, as an incurable condition for which nothing can be done, has been replaced by the conviction that, even with the methods now at our disposal, worthwhile help can be given to all retarded and that the majority could be rehabilitated.

Pioneer work has already been done in the development of community day centres for trainable children, special classes within the regular school system for the educable retarded, vocational training placement and supervisory services for those who can be helped to self-support in the community. There are shelter workshops for those who must remain semi-dependent, improved residential facilities for those who require them, and certain counselling and consulting services for the parents of retarded children. As yet, services of this kind are few but there seems every likelihood of their rapid growth in the years ahead.

Adequate medical diagnostic and counselling services are a very essential component of any expanding over-all program for the help and the rehabilitation of the retarded. Unfortunately, since mental retardation is not a single disease entity, but a condition whose basic cause may be physical, psychiatric, educational or cultural, adequate evaluating services are not easy to provide. Several suggestions of merit have been made. One is to increase the amount of medical teaching in this area, both at undergraduate and postgraduate levels; another is to extend the resources of com-



Endocrinology experimentation is part of large research program.

munity mental health clinics where the services of the psychiatrist, psychologist, and social workers are already available.

More recently there has been a trend towards special clinics for the retarded. The first was established in 1950 in New York. Since then, some dozen others have been established in the United States.

In June, 1956, such a clinic was established at the Montreal Children's Hospital. It was envisaged that the mental assessment and guidance clinic, as it was called, would accept referrals of retarded children coming to the hospital and serve as a point of co-ordination for the various consultant services available to these children from existing departments within the hospital, such as medicine, neurology, genetics, and speech. Above all it would provide a continuing personal contact with the child, his parents, and the agencies in the community concerned with him, extending to them whatever was necessary in the way of interpretation and counsel.

The clinic is staffed by a full-time medical director, trained in psychiatry; a psychologist; and two part-time social workers. Referrals are accepted from departments within our own hospital, from doctors outside, and from schools. In all cases, a medical examination by the family physician, or in our own medical out-patient department, is a routine part of the process.

Where possible, we like the parents to come to the clinic in advance so that a developmental history can be obtained, and an appraisal made of the child's life experience. This also affords an opportunity to learn of any factors in the family relationships which would be relevant to the problem. Interpretation of the function of the clinic to the parents, and development of constructive relationships, begins at this time. Psychiatric and psychometric examination of the child follows. Whatever special examinations may be indicated, such as electroencephalography, are obtained. Due to location of the clinic within a hospital with a full range of consultation available, we are in a position to offer a quite comprehensive diagnostic service.

Our experience to date indicates that our greatest challenge will be in the area of helping children and their parents adjust constructively to their difficulties. With a growing case load, individual casework and psychotherapy becomes im-



Wash-up time for dolls in group guidance and play therapy area.

practicable due to lack of time. Group therapy for parents and children has been employed in this area and is said to have given encouraging results. We have begun to use the method here with some modifications which we think might prove to be of merit. Besides running separate groups for the children and their parents, we provide opportunity for the parent group to observe the sessions with their children through a one-way screen. This process of imposing, through manipulation of the physical set, some degree of objectivity in the relationship between parent and child has an impact on the parents. This, we have found, has a carry-over and use in their own group meetings. Direct confrontation with the child's reactions, needs and problems gives an immediacy and concreteness to their own group work which, it seems, makes the parents' group move much faster.

We are fortunate in sharing floor space and facilities with the day treatment centre for autistic and schizophrenic children. While our main concern for some time to come will be with improvement of the kind of service we offer, it is our hope that, in collaboration with the staff of the day centre, we shall be able to contribute some clinical formulations about the relationship of retardation to typical patterns of personality development. — *John Stanley, M.D., Director.*

group guidance

GROUP guidance is a very new type of department in hospitals. The Montreal Children's Hospital was the second to start such a program. Though there are no departments in other hospitals called group guidance, there are many similar programs. As there is no special college course to train people for group guidance work, the department at M.C.H. is staffed by professional psychologists, group workers, and educators.

The basic interest of this department is in the emotional and social well-being of the children while they are in hospital. The department works toward this general objective through programs for the child patients, education of the hospital staff, planning for patient care and research and publications.

Programs for Children. Play programs for the wards are conducted by the nurses, volunteers and department staff. The hospital teaches comprehensive nursing care which means that, among other duties, the nurse is responsible for the play needs of the child. Group guidance staff help the nurses develop understanding in techniques and materials in the area of play. The nurses are assisted by staff and by volunteers trained and supervised by the department.

Children with special problems or

needs are occasionally referred to the department for play therapy. This is a form of psycho-therapy and is carried out by the professional staff of the department.

Education of the Hospital Staff. Group guidance participates in the education of the hospital staff, sharing its resources in child psychology, group work, and education. It is especially active in the training of nurses. The staff are also available as consultants in educational methods and techniques and in evaluating the teaching-learning process.

Planning for Patient Care. Group guidance shares in planning for patient care by describing the emotional and social needs of patients, outlining the factors affecting these needs, and helping to develop the implications of these needs for staff planning. The staff also contribute to the improvement of group procedures and development of these planning groups. The applications of group process (group dynamics) are worked out for staff planning, conferences, workshops or institutes, inter-departmental relations and communications.

Research and Publications. Research is undertaken that will advance the understanding of the factors affecting the mental health of hospitalized children. The staff also share their resources in research design, sampling, and large

group statistics, with staff and community groups that are interested. The special research area of the department is social, survey, and small group research. Each year the department staff contribute several publications toward the advancement of the field. Community groups have also made many uses of the specialized resources of group guidance staff.

—H. Dimock, Director.

speech clinic

THE SPEECH Clinic at the Montreal Children's Hospital has two functions; assessment and treatment of all disorders of speech. Treatment programs are integrated with the work of other departments of the hospital in attempting to give the very best diagnostic and treatment service to the patient. Some of the treatment programs include groups for stutterers and their parents, groups for language disorders, articulatory defects, and parents' groups, as well as a program of intensive individual therapy. Included in these are organic problems of speech and language, such as those associated with cerebral palsy and brain injury, cleft lip and palate, hearing deficiencies, and voice disorders due to organic pathology or functional etiology.

The unit includes a social worker who evaluates and comments on

family and social factors and contributes greatly to the planning and treatment of many problems. The social worker takes one of the mothers' groups dealing especially with problems of delayed language development. The department of psychiatry also contributes a great deal to evaluation and treatment of children who stutter, by conducting individual psychiatric evaluations where required, and by leading parents' groups. The department of psychology provides assistance in both screening and planning, as the program is concerned with the totality of a problem and not just with a speech symptom. The total team approach is utilized in dealing with all problems.

The speech clinic participates in hospital rehabilitation programs for the cerebral palsied, children with cleft palates, and in hearing problems. The speech therapist's role in this program is to provide speech evaluation, to attend and participate in conferences and, where required, to provide treatment.

In the cerebral palsy program the speech therapist participates in the pre-school group program, where speech therapy is provided as part of the day's activity. The therapy for children referred by the cleft palate conference usually involves individual sessions. There is participation, too, in the speech clinic where children who are hard of hearing may require speech therapy, lip-reading and auditory training, preparatory to the use of hearing aids.

From the various clinics we receive many kinds of problems; from the medical clinic, language and speech retardation problems; from the otolaryngology clinic come voice problems, as well as some of hard-of-hearing youngsters who come for speech therapy, auditory training and lip-reading. From the neurology clinic are referred children with brain damage; from plastic surgery come palate problems. The departments of psychiatry and psychology refer special reading problems and the orthodontic department refers cases of articulation difficulties.

Aside from the regular clinic, which is conducted six days a week, the hospital has a summer program specifically for children with speech and hearing problems who are unable to make use of the clinic services during the year. Children are evaluated by the social service and psychology departments as well as



Volunteer assists children in play therapy activities.

by the speech clinic, to determine the child's fitness for "camp" program. To date the summer camp program has been integrated within a large regular camp. The children are seen by a speech therapist as part of their daily program. This program is conducted for six weeks annually. — *Mrs. Mary Cordozo, Director.*

physiotherapy

THE PHYSIOTHERAPY department of the Montreal Children's Hospital has an excellent physical set-up. The main department is on the third floor, while on the second floor is a very large gymnasium for out-patients, with a waiting room, two shower and cloakrooms, and an office. The fifth floor has an additional gymnasium for treating children in the pre-school cerebral palsy group—part of the rehabilitation department for brain-damaged children. Despite the divided physical facilities, co-ordination with nearby departments is possible.

The main department has offices for the director, assistant director, and secretary, and four treatment rooms where other staff members give individual treatments requiring quiet. Beyond is a medium-sized gymnasium with wide treatment tables, floor exercise mats, wall bars for remedial exercises, adjustable parallel bars for gait training, a large wall mirror and one on wheels for posture training, and various portable equipment. The floor features black footprints inlaid on yellow background for foot posture training—and highly entertaining to children. The



Hydrotherapy treatment in physiotherapy tank

floor was presented by the Zonta Club of Montreal.

Beyond the gymnasium, at one end of the department, is the electrotherapy room with windows on two sides overlooking the city and river. It has the essential equipment for children: ultra-violet lamps, kromayer, short wave, bakers, infra-red, wax baths, and machines with diagnostic currents for muscle and nerve tests and treatments.

Along the corridor, beyond the office, are a waiting room, wash room and two white-tiled pool rooms, with shower and dressing rooms between them. One pool room has an electric hoist and a modern Hubbard tank and agitators, and a deep trough with parallel bars for gait training; the other pool room has a whirlpool bath and a steel tank where swimming exercises can be taught. It is long enough for tall children yet shallow enough to delight younger ones.

Next to the hydro-therapy section are a staff conference room, also used for teaching students, a staff cloakroom, and a large walk-in linen storage cupboard.

One floor down is the large gymnasium, a beautiful fan-shaped room, some 40 feet across at its widest. It has three robin's-egg-blue walls and the fourth under the high windows is yellow. Sunlight

floods in on fine days and, when dark, overhead lighting and a series of aluminum wall lamps over the eight treatment tables are more than adequate. In addition to apparatus described in the other gymnasium, there are climbing ropes, balance beams, and much space for activity exercises in class work for postural deformities. The floor, with inlaid footprints leading into a large wall mirror, a small badminton court and two shuffle-board courts for shoulder exercises, was also given by the Zonta Club of Montreal. A storage cupboard, two cloak and shower rooms, a waiting room and office, complete this section. It is very near the orthopaedic clinic, whose surgeons refer many patients. Transportation for patients, from all sections of the city, is supplied by the Province of Quebec Society for Crippled Children, and at least ten volunteers attend weekly to help with telephones, filing, and non-technical work.

On the fifth floor a somewhat smaller gymnasium has exercise mats, treatment tables, parallel bars with low middle bar to prevent scissor gait, and canvas beds for rest periods—which can be stacked when not in use.

Some 20,000 treatments are given in the department each year, for a large variety of conditions and diseases such as poliomyelitis, frac-



Inset footprints amuse and instruct young patient in walking.

tures, cerebral palsy, asthma, cardiac and chest conditions, scoliosis and other deformities, and skin conditions. Work is undertaken on all wards, including pre- and post-operative breathing exercises; the latter are given in the recovery room.

The physiotherapy staff members, seven full-time and two part-time, are all trained in Canadian universities or English hospital training schools and are members of the Canadian Physiotherapy Association. In addition, a full-time secretary and a part-time assistant keep records, reports and statistics up-to-date. The director of the department is a qualified teacher of physiotherapy and physical education; and each physiotherapist is responsible to her for a section of the department—wards, electrotherapy, hydro-therapy, gymnasium, pre-school, private patients, and a section of approximately 70 children at the nearby School for Crippled Children. Physiotherapy students, numbering 15 to 20, spend varying hours in the department each month, receiving instruction and treating patients under supervision. All treatments are ordered by doctors to whom the director is responsible. She is in turn responsible to the executive director of the hospital for all matters of policy decision. The director does ad-

ministrative work, sees patients, gives lecture demonstrations to medical students, physiotherapy students, post graduate nurses and others. The assistant director coordinates and teaches physiotherapy students and assists in department organization and treatments. The students come from McGill University and the University of Montreal and, in summer, from the University of Toronto.

Much co-operation with other departments is necessary; meetings are attended regularly in which doctors and members of teams share the planning for total patient care. Parents' instruction periods are essential for home exercise supervision, and a senior physiotherapist visits homes to assist in planning home apparatus and care.

The keynote for children of all ages is to get them interested in play or work exercises and to give them ambition to help themselves. Their eagerness to learn to walk, and to use their limbs adequately is the reward for the patience of the successful physiotherapist.

In this new hospital building the interior decorator has given us colour to delight the eye, the architects lines and space, and the happy spirit has come with us from the old hospital, which makes work within its walls a constant joy.

—Mrs. S. G. Vatcher, Director.

occupational therapy

THE OCCUPATIONAL therapy department at the Montreal Children's Hospital was organized in 1936 to provide treatment through participation activities devised to aid patients in recovering from injuries and disease. In 1940 the department was closed when its maintenance became financially impossible. After the war, through the generosity of the Knights of Pythias, the department reopened in 1945. It was specified that recreational and occupational therapy be combined to the fullest possible extent; so the department became known as the "occupational and recreational therapy department". A staff of five therapists carried on both recreational and occupational therapy programs until May, 1952, when the recreational programs were transferred to the new department of group guidance. Since then the department of occupational therapy, staffed by four registered occupational therapists, has directed its efforts toward rehabilitation of the children being cared for at the hospital.

The occupational therapy department today, situated on the third floor in the new hospital building, has outstanding facilities. Two individual treatment rooms provide excellent space for both "noisy" and "quiet" patients. Situated apart from the rest of the department, they are furnished with a minimum amount of equipment, thus providing a quietening atmosphere.

The main treatment area consists of two large, sunny rooms, separated by a glass partition which allows the therapist full view of her patients from either room.



These rooms contain the necessary equipment and materials used in the treatment of patients. Woodwork, leatherwork, copperwork, and basketry areas are situated in one room, while sewing, weaving, artwork and remedial games are grouped together in the other. These areas provide full facilities for the treatment of both inpatients and outpatients. The department director's office, staff office and conference room complete the department. The offices are the hub; here are kept the various departmental records, supply forms and occupational therapy prescription referrals. The staff conference room, situated in what was formerly a solarium, serves also as a student reading room and extra storage area.

At weekly staff meetings the four therapists are assigned to the various treatment units of the department. At present we conduct out-patient treatment in the mornings and in-patient treatment in the afternoons. Each morning, Monday through Friday, outpatients are treated in the main area of the department. These patients are transported to the hospital by the Province of Quebec Society for Crippled Children and are mainly cerebral palsy and orthopaedic patients. With these patients, the emphasis in occupational therapy is placed on increas-

ing the child's ability to use his hands in order to gain independence in self-help skills such as dressing and feeding.

Thrice weekly a staff therapist is assigned to treat patients attending the pre-school cerebral palsy clinic. Each child in the clinic receives intensive treatment by the physiotherapist, occupational therapist, speech therapists and school teacher, who work as a team toward rehabilitation of the child. Once again emphasis is placed on teaching the child to be as independent as possible in the various activities of daily living—feeding, grooming and dressing.

During the afternoon, therapists proceed to their assigned wards to treat the individual patients who have been referred to the department. On the ward where the children are convalescing from rheumatic fever, occupational therapy is provided through a program of graded activity within physical limitations necessitated by their illness. On the orthopaedic ward, where children are confined to bed usually in a cast, the aims of occupational therapy depend upon the diagnosis of the patient. This also applies to patients referred from all other wards of the hospital.

During the later part of the afternoon, ambulatory and wheelchair patients may receive their occupational therapy in the main

department if so indicated by the attending physician. Inactive, at the present time, are two treatment services of this department: the home visiting service for cerebral palsy, and the School for Crippled Children service.

Ths being a teaching hospital, the department of occupational therapy accepts, for clinical training, students in the combined course and the diploma course of physical and occupational therapy at both McGill University and the University of Montreal. Also, undergraduates and graduates of the courses at McGill University, University of Montreal, and the University of Toronto, are accepted for internship periods during the summer months.—*Mrs. J. A. Winterson, Director.*

grade school

ACCORDING to the law of the Province of Quebec, the Department of Education is divided into two committees, Protestant and Catholic; each committee being responsible for the education of its respective division of the population. Jewish children attend Protestant schools; other non-Protestant, non-Catholic children may attend the school system of their choice. Schools under the Protestant committee are financed by the Protestant panel of school taxes;



Occupational therapy classes include lessons in buttoning and unbuttoning as well as block building.



School is carried on as usual in the hospital.

Catholic schools are kept up by taxes from the Catholic panel.

Local school authorities appoint teachers to the hospital as they would to any regular school in their district. Thus in the Montreal Children's Hospital there is a department of studies composed of four teachers representing the main groups in the population: English, French, Protestant and Catholic. Each teacher works only with the patients who would ordinarily attend the schools of his or her own religious or language group. Hence, French-speaking children are taught by a French-speaking teacher; English, by an English teacher and so on. Whenever the health of the child and the time at her disposal permit, each teacher follows the program of studies laid down by the school board to which she is attached. The teacher must be prepared to teach all grades from grade I to second year high school. Text books and educational supplies are supplied by the various boards. Hours for lessons are nine to four, and the regular school holidays apply. School registers and records are open to examination by the provincial inspectors who visit twice a year. School board examinations are held when required, and the corrected papers are sent to the patient's schools.

Accommodation for the department of studies consists of a classroom, an observation room and an office. By means of folding doors,

the class-room may be divided into two smaller rooms so that two teachers may work at the same time with different groups. The observation room, with its one-way-vision glass panel, is for the convenience of visitors who may watch without disturbing the lesson. It also facilitates the observation of behaviour in case-studies. In the office, individual educational assessments are made and the clerical part of school work is done.

In the Wards. Every child whose hospitalization period is one week or more is expected to "go to school" daily, if his physical condition permits. Most of the bedside teaching has to be done on an individual basis; in this case, the child receives approximately thirty minutes of instruction a day. The ever-increasing patient load keeps time down to a minimum. Wherever possible, grouping of beds saves time and is quite satisfactory.

In the Classroom. Every afternoon, groups of ambulatory patients come to the classroom. Here, with blackboard and other regular school equipment, children have group lessons in the major subjects of the curriculum. Homework is assigned to all pupils and, in some of the wards, the nurses arrange a study group period when the assignment is done.

Achievement. The past educational achievement of a new patient must be established before lessons are commenced. The teacher then

continues along the same lines, so that subsequent to his discharge from hospital the child will more easily fit into his regular school program again. If a patient has spent over a month in the hospital, a written report of work done is forwarded to the social service department and to the patient's school.

Out-patients. A recent development is an additional service to children who, following their discharge as in-patients, may continue to return to the hospital for two lesson periods a week, until they are able to return to regular school.

Kindergarten for the Cerebral Palsied. Three days a week, twelve cerebral palsied children of five and six years of age come to the preschool. Here they attend physiotherapy, occupational therapy, speech therapy and kindergarten classes where they are grouped according to language and mental ability. Four to six children form a class.

The kindergarten period is divided into individual sense training and group activity. The Montessori method is used as a basis for sense training. Here the environment is "prepared" in the form of educational apparatus which is planned in accordance with the child's individual needs. The "toys" are placed where they are easily accessible and the child is free to choose his own activity. Group games are two-fold in objective: they are

psychological and pedagogical in that they aid social adjustment and prepare for the basic skills. Some games lay a basis for number concepts, others alert the ear to phonic differences in words, others are happy experiences in visual perception and visual memory. Others again prepare for the eye-hand co-ordination of writing.

A second group of cerebral palsied children attends the out-patient department. This group comprises ten children who come twice weekly for one-hour periods. These are young children whose present condition does not indicate the intensive treatment of the pre-school, or children who, for various reasons, are unable to attend regular school.

Assessments. Referrals for educational assessments frequently come from other departments, and those are handled in the regular manner, using various standardized tests.—*Joyce Wood.*

out-patient department

THE MOST notable feature of the out-patient department at the new Montreal Children's Hospital is the up-to-date, functional equipment. Practically everything is of stainless steel, including examining tables, desks and cabinets. Many of the clinic rooms have specially designed individual cabinets, fully-equipped, and in readiness for each doctor. This eliminates the necessity of the nurses "setting up" the clinic.

The medical unit consists of 20 private examining rooms for the attending and intern staff, where they can study the individual and discuss family problems—numerous in any paediatric medical clinic. Each room is provided with complete facilities for physical examination and also for certain tests and minor treatments. Mobile equipment is arranged so that major treatment can also be carried out in these rooms when desired. A large room used by the nurses as a treatment room is available in the area. There is an adjacent weighing room where all children are weighed and their temperatures taken before being examined.

A medical appointment clinic is gradually being developed but at the moment this applies only to "return visits". However, even when this is in full operation, any sick child will be given attention at any time in the out-patient department.

The entire medical unit is in use



Out-patient department waiting room with snack bar operated by auxiliary

as a medical clinic each morning when certified paediatricians and intern staff see a daily average of 100 patients—and their families.

Since this hospital is a teaching unit affiliated with McGill University, the third year medical students attend teaching clinics—held in the O.P.D. lecture room daily and staffed by certified paediatricians.

Medical specialty clinics are held in the afternoon and cover the fields of allergy, cardiology, dermatology, metabolism and neurology. As with all specialty clinics, they are not only directed by, but are attended by the specialists in the various fields, assisted by their resident and graduate students.

The surgical clinic has a control area from which the nurse controls two large and nine small examining and treatment rooms, used for clinic purposes. Each examining table has individual medical and surgical supplies in specially designed units.

There are two minor operating rooms and one plaster room completely equipped with the latest in operating room and anaesthesia equipment; these are ready at all times for emergencies, referrals from the clinic or for the posting of cases which can be treated on an out-patient basis, whether the child be a private patient or from the clinic. Emergency service is maintained 24 hours a day.

An eight-bed recovery room—with suction and oxygen piped from the central supply to each bed and all the facilities necessary for the complex care of the post-operative patient—is situated in the out-patient operating area.

Special attention has been paid to the departments of dentistry and

ophthalmology; each has a self-contained unit of several rooms. The E.N.T. department has its audiometric equipment and sound-proof rooms.

All laboratory and special services which are available for the private in-patients are equally available for the free clinic patients. In addition a clinical laboratory is situated on the clinic floor. Workers from the social service department serve all the clinics.

The average number of O.P.D. visits for the past four years has been 65,000 annually. At the present rate of increase in visits it is anticipated that the 1957 figure will exceed 75,000. However, numbers are not important; we hope to continue treating our young friends as individuals and not as statistical entities.

When fully organized, the out-patient department will be under the direction of the full-time certified paediatrician with a full-time chief resident as assistant.

—*O. MacInnes, R.N., Supervisor.*

social service

THE SOCIAL service department of the Montreal Children's Hospital reopened in 1947 after having been closed during the war years. Since that time the department has been expanding and developing in accordance with changes in the hospital program, increasing interest in the comprehensive care of the total child, and government aid in establishing special services for the rehabilitation of children with specific illnesses and physical disabilities.

The functions of the social service department can be defined as: (1) practice of social casework;

and (2) participation in program planning and policy formulation within the hospital, in the development of social and health programs in the community, and in the educational program for professional personnel, and social research.

The professional training of the social caseworker has been directed toward helping individuals and their families work out problems of social adjustment concerning which they wish and can use help. In the Montreal Children's Hospital the problems which originate in or accompany illness or permanent disability of a child are those which are the concern of the hospital caseworker. Close liaison with community agencies enables the caseworker to make appropriate referrals when the family problem is not illness-centred.

In work with the child and his family, the caseworker does not operate independently but in close co-operation with the medical staff of the hospital. Each caseworker is assigned to a particular hospital service, and receives referrals from doctors, nurses, and other professional personnel on that service.

One of the largest and most comprehensive services developed by the hospital in recent years is the rehabilitation program for the cerebral palsied child. As this condition can range in severity from a slight awkwardness in walking to almost total disability, with impairment in the motor function, intelligence and all sensory functions, the diagnosis and treatment of these children necessitates the active participation of many disciplines, one of which is social casework. The social worker sees, for purposes of evaluation, every parent whose child will be included in the program. The purpose of her work is twofold: first, to obtain a picture of the environment—physical, social and emotional—in which the child lives so that the rehabilitation team can individualize the child's treatment program, according to his needs and those of his family. And secondly, the caseworker's function is to offer continued service to families who need special help with problems related to the child's handicap. For example, a mother, because of her feeling that she was responsible for the child's injury, which occurred at birth, may develop an over-protective attitude toward him, which makes it difficult for her to allow him to attempt, at home, independent activities which are part of his treatment. She must, there-

fore, receive from the caseworker some help in understanding her own attitudes toward the child before she can use the instruction in treatment procedures which she receives from the physiotherapist and occupational therapist.

Employment by the hospital of social workers, psychiatrists, and psychologists, in what were considered in the past to be purely physical treatment programs, reflects acceptance of the principle of treating the whole child rather than the specific disability.

The form of treatment has been influenced accordingly. For example, the out-patient nature of the program is a reflection of the recognition that separation of the young child from his family for long periods of time is detrimental to his over-all development. Similarly, groups organized primarily for treatment purposes have the advantage over individual therapy of giving the handicapped child opportunities for social development through association in therapy and play periods with others of his age group.

With respect to patient management, the hospital program for the child with rheumatic fever differs greatly from the cerebral palsy program. Here, hospitalization of a long-term nature is unavoidable and the role of the social worker varies accordingly. The child and his parents may require casework help in understanding and adjusting to the illness and the separation it entails.

Parents' anxiety about leaving their sick child in the care of strangers, complicated by lack of understanding of the disease process itself, may result in removal of the child from care against advice. Part of the social worker's role is to detect these and other problems when they are present; and to help parents accept the child's illness and the accompanying disruption of family routines and relationships. Early attention to the effect of the illness on the family often serves to prevent crises from arising; and it ensures close co-operation between child, family, and hospital staff, both during the hospitalization and during the period of continued supervision following discharge. Since prophylactic measures are necessary until the child is adult, problems of follow-up can be prevented by ensuring that the family understands fully the implications of rheumatic fever during the per-

iod of acute illness, when the closest contact with hospital staff is possible.

Not only the family, but the child himself, may require the services of the caseworker. The child who has trouble adapting himself to the life of the ward may be giving evidence of anxiety about his illness, or may feel rejected by his family because he is away from them. Failure to help him with these feelings may result in disturbing behaviour problems, hyperactivity, refusal to rest, all of which prevent adequate treatment of his disease.

The caseworker's service to the child and family is offered as part of total treatment and is closely related to the work of the rest of the medical team. Periodic conferences with other staff, both on an informal and organized basis, provide opportunities for joint consideration of the child's treatment plan. Plans for convalescence, for example, are made by the medical team, with consideration of the social facts and knowledge of family relationships which are contributed by the social worker. Discharge is arranged immediately after the acute phase of illness or is delayed, depending on the material and personal strengths of the family concerned. Community resources may be used to strengthen the home and make early discharge possible; for example, when special diet, schooling, or physiotherapy is required.

The activity of the social work staff in the hospital is by no means restricted to the medical program described in this article, but is extended to most of the major medical and surgical services, and to the department of child psychiatry.—
Barbara M. Allan, Asst. Director.



Auxiliary's toy shop



Main kitchen

Food Service

sponsored by the
Canadian Dietetic Association



Service counter of main cafeteria

food service

THE MOVE of the Montreal Children's Hospital to new and enlarged quarters brought many changes to the food service department. Inside of 24 hours both the responsibilities and the staff of the department were doubled and the changeover from the old hospital to the new was accomplished without tie-up or delay in service between breakfast and dinner.

In its new capacity, the department includes a central main kitchen with adjoining semi-partitioned areas for a bakeshop, vegetable preparation and salad rooms, portion and ingredient control rooms, special diet kitchen and a small store-room for daily dispensing. It also includes nine small kitchens, one for each ward, two kitchenettes to serve day patients in the rehabilitation clinic and clinic for emotionally disturbed children, as well as a special metabolic kitchen. It also includes a spacious and modern cafeteria, seating 240 people, with a separate dining area for parents and guests of the hospital. The department is also in complete charge of its food storerooms.

The main kitchen is ideally located on the top floor of a four-storey service building with a direct elevator to the cafeteria, main food storeroom and receiving area. The building itself lies between and is joined to the main wings of the hospital (see floor plan). The main kitchen produces all food used in the hospital by both patients and staff.

As in all other large hospitals, the transportation of food to the patients is a major problem and mobile food trucks are used to service each floor. These trucks use rectangular inserts, felt to be advantageous in a children's hospital, rather than the deep round wells commonly used. The inserts are 12 by 20 inches, or a division thereof, and up to six inches deep. This allows more storage space for the different kinds of food used by children of various age levels. The infant wards are serviced by small, mobile units, having a 12 by 20 opening which holds a rack of up to 12 small covered containers. These racks may also be used in the drawers of the large trucks for carrying special diets.

The CANADIAN HOSPITAL

The trucks are pre-heated in a separate truck storage area at one end of the kitchen. When properly heated they are rolled into the kitchen and pick up their food from a 26-foot long stainless steel electrically-heated holding unit. This holding unit's top has rectangular wells with hinged covers. Extra storage area is provided by heated shelves underneath. This holding unit is co-ordinated to hold the same type of inserts as the trucks and, as each truck rolls by, it picks up food for its ward. The trucks then move out the other end of the kitchen directly onto the elevators.

On reaching the wards each truck is again plugged into special outlets located in the main corridor. Tray carriers, which have been set up in each ward kitchen, are rolled out to stand beside the truck and food is in this way served as close to the patient as possible and in the shortest possible time.



Cafeteria seats 240

The main cafeteria, located directly below the main kitchen, serves all hospital staff. The service counter of the cafeteria, especially constructed at the time of the move, is 50 feet long and contains refrigerated and heated sections. A back bar of heated and refrigerated pass-throughs provides extra storage. Food is taken to the cafeteria in specially built, closed, heated trucks. At present the cafeteria is serving up to 960 meals a day as well as an additional 600 people for tea and coffee breaks. It is a congenial and restful area where the staff can enjoy their meals in a relaxed atmosphere.

At the time of the move the cafeteria was put on a pay basis, making it possible to offer a choice of food. This has proved an extremely satisfactory arrangement for all concerned.

To its other new responsibilities, the food service department has also added a formula room, which prepares and distributes all formulae used in the hospital. The formula room comprises two areas; the bottle washing area where bottles and nipples are washed in special machines, and the formula room itself. In this area the department has pioneered the use of the terminal sterilizer in Canadian hospitals. The virtue of this unit lies in its extreme simplicity. It is a unit especially designed for the sterilization of formulae and entirely eliminates the use of sterile technique. In one continuous cycle the machine takes care of water inlet, heating of the formulae to 212 degrees Fahrenheit, at which temperature they are held and sterilized and then cooled. The whole cycle is completely automatic and takes one hour. At the end of this time the formulae are ready for immediate refrigeration. Each terminal sterilizer can sterilize approximately 50 to 70 bottles in one cycle. The units, each measuring 20 by 40 inches, can be banked and each operates independently of the other. The use of the terminal sterilizer eliminates the more costly autoclave and separate cooling unit with its consequent extra labour.

Excellent working conditions have done their part in increasing work output and in creating a more competent staff. In every way, the hopes held by the department for improved efficiency and service have been fully realized due to careful planning of the physical layout.—

Elinor B. Wolff, P.Dt., Assistant Director.

THE purpose of this article is to generalize on the theme of ideal or optimum desires in hospital administration, rather than dealing with any one aspect of this very broad subject. In doing so may I quote the words of that great and honoured man, the late Dr. Malcolm T. MacEachern, whose name is synonymous with hospital administration:

"With a background of centuries of struggle there has evolved the 'hospital' of the twentieth century. It is the expression of man's inalienable right to be well and is the formal recognition by the community of its responsibility for providing the means of keeping him well or restoring lost health. This right and this responsibility belong to all strata of society".

Dr. McEachern's words will remain as a guide to administrators for decades to come.

Management, or administration, is an art. It is not likely ever to become an exact science, but it is an art increasingly based on science. The art of management is in a constant state of flux and change—just as is the art of medicine.

While hospitals may vary in size and scope of work, there are aspects which would be considered common to all hospitals. The association of persons drawn together from all types of industry and professions, whose common interest has been the improvement of their practices for the welfare of the patient and a better hospital of tomorrow, is the point I shall endeavour to discuss.

Service is not a cold, impersonal business, devoid of friendliness and fine human conduct, but rather a warm and pleasant relationship between people, sponsored and developed for mutual benefit, with an instinct to serve—organizationally, with ability, sincerity of purpose, initiative and, above all, common sense. The world bestows its biggest prize in money and honour for but one thing—initiative. All it means is doing the right thing without being told, but next in importance to doing the thing without being told is to do it when you are told once.

Thoughtful men and women concerned with management have accepted the importance of analyzing the activities of all administration

From an address presented at the Western Canada Institute for Hospital Administrators and Trustees in Vancouver, June, 1956.

The Administrative Ideal

L. F. C. Kirby,
Director,
Royal Columbian Hospital,
New Westminster, B.C.

into basic processes. They group them under such general headings as planning, organizing, directing, co-ordinating, controlling and so forth. Each of these processes, then, should be examined to see what laws or principles can be defined. Appreciating that all management is the management of men, they turn to the social sciences for guidance on such common management problems as incentives, habit formation, group dynamics, fatigue, logic, and so on. Management accepts the scientific assumption that every event is the result of discoverable causes and, at any level, in any economy, attempts to control these factors. This policy in administration is in terms of six basic processes: definition of objectives and goals; planning, policy formation and techniques; personnel relationship; organization and co-ordination; control and appraisal; and direction and communication. The administrator must make sure that cross-communication between department heads and services is taking place. It will not automatically happen.

When a business organization is formed, it has a single goal or objective, namely, to discover, produce, or distribute some commodity or service. As time goes on, the need for clear definition of its objectives, both short-term and long-term, must be recognized if the enterprise is to survive and succeed. The success of the smallest or largest hospital's operation depends upon organization.

Budgeting is a practice created by management as an activity for our own good and economy of operation. Its use is at times painful, but in some form or other it is inevitable. Budgeting means planning, forecasting and co-ordinating the entire operation of a business

or hospital. It is a control measure which results in assigned responsibility. Loyalty, responsibility, and obligation are the primary duties of every employee. Our stability and progress will continue only as long as we continue to provide good service, regardless of our position, in the interest of patient welfare and due tolerance of fellow employees.

Tolerance covers such considerations as courtesy, dignity, friendliness, attention to individual problems, promptness, importance of extreme care in carrying out orders, and protection and economy in the use of hospital supplies and equipment, and so on.

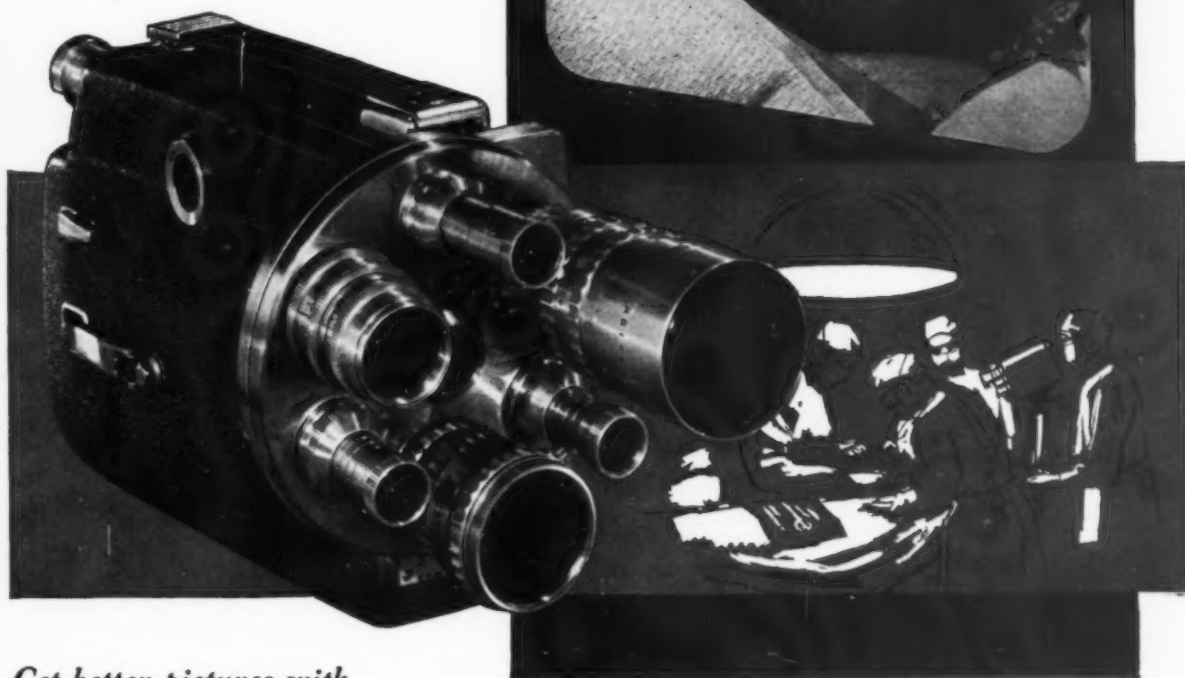
Any employee worth his salt has a certain amount of pride. He will take, with good grace, sharp reprimands in private, which, if administered in the presence of others, would fill him with a deep sense of shame and bitter resentment. Likewise, remarks that reflect on an employee's intelligence and ability are costly to the hospital, for they destroy the self-confidence and pride that are so important and necessary in our field of endeavour. The seasoned executive will not allow his blood pressure to rise, in the event of a damaging report, until he has heard both sides of the story; and I doubt if it is ever justifiable to become excited. Deal with the problem with strategy and authority, showing always humanity and civility. When mutual respect, confidence, and over-all understanding exist between those who labour and those who manage, the relationship cannot help but be one of goodwill. Somewhere I read, and I quote:

"This living flame of belief in one another and in the future, the capacity of people to change, to learn from experience, to become greater than they are—this is an important part of man's legitimate pride".

In our daily life about the hospital, one must deal with, for in-

(continued on page 58)

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Administrative Ideal (continued from page 56)

stance, the public, other institutions, tradition, all strata of human life, budgets and finance; but of these individual matters none means so much as the persons themselves, professional or non-professional, for they are all human beings. This, then, is perhaps the secret to successful administration, for no one man or woman can successfully operate so complex an organization as a hospital. It is co-operative and creative thinking that achieve the end result. To achieve the utmost in management control, efficiency of operation and complete understanding of our functions depends upon responsible co-ordination and inter-departmental liaison. Everything you do has either a positive or negative effect—plan together to get the right results.

There are pitfalls in our business, just as surely as in any other, but, if we try to avoid the following, we will not go too far astray: (a) neglecting or never acquiring the habit of reading and studying; (b) refusing to set aside trivial preferences; (c) the delusion that individual advancement is made by crushing others; (d) the tendency to worry. Worry is like a rocking-chair—it gives you something to do, but it doesn't get you anywhere.

Delegating Authority

The process of delegation is very important. The executive who delegates continues to take responsibility for the actions of subordinates; and this should be clearly defined for the person concerned—by written instructions, illustrations or organizational charts, and planned supervision. With responsibility must go authority (permission), not power. Authority and responsibility must be co-terminous and well defined. It is an accepted principle of organization that a person cannot serve two masters and maintain good morale. Expression of profound truth, tradition, dress, leadership-qualities, evidence of a sense of loyalty, all help to secure acceptance of authority.

In actual practice, delegation is restricted by standing orders or plans, and by specific limits of permission (authority). As delegation and decentralization increase, more and more attention must be given to communication if the unity of the organization is to be maintained.

Committee work on policy forma-

tion and planning is invaluable in the following situations:

1. When several departments possess data which is needed;
2. When a plan needs to be sold to a large group, or when it is desirable that a well-planned job should be used as a training device;
3. Psychologically, if for no other reason, the answer arrived at by a group of qualified persons is better than the answer of any one individual.

Planning

The making of important decisions and interpreting policy is a burdensome task, but is an inevitable element in all levels of administration or management. Planning is a detailed job which occurs in every department and in which executives at every level are involved. No business can operate without plans. Planning has become one of the most time-consuming phases of our business life today for reasons I have stated. The dynamic nature of business activity demands constant changes in objectives and goals; and the constant revision of plans, methods and techniques is an inevitable consequence. There are several steps to follow that will help in assessing a problem:—

1. Analyze a job into its elements and eliminate the unnecessary ones;
2. Fix a working pattern;
3. Encourage motion study and method study;
4. Determine the component elements of job analysis;
5. Prepare a job specification;
6. Continue to experiment with every phase.

The application of techniques, methods and planning is limited by

the size of the operation, then by the type of function being performed. In small operations, the chief executive does much of the detail planning and thereby obtains more uniformity with less risk, more speedy decisions and better motivation. The larger the operation, the more difficult this becomes. There should be frequent review of both small and large operations. While the small operation tends to be deficient in standing orders, in the large operation standard procedures may frustrate and may lead to stagnation. Planning is creative as well as analytical. All planning raises questions of human relations and organization. Plans should be stated quantitatively wherever possible, that is, personnel, space, time, equipment, safety, size of job, scheduling, cost requirements, et cetera. It is said authoritatively, and I quote:

"The essence of modern management is the process of defining with skill, logic and common sense what is to be done, fixing responsibility for planned results, with wide freedom of judgment to executives as to the know-how".

Leadership Skills

Constant attention must be given to the development of leadership skills, remembering that approximately 40 per cent of management is specific "know-how" and the other 60 per cent is ability to work with others. Obviously, the use of specialized staff for planning, or the use of time of a regular staff for this purpose, must pay its way. Whether the operation is small or large, review and refinement of the organizational structure is one of the duties of all levels of management—one of the essential tasks of administration. Organization is not an end in itself; it is a process carried out in order to achieve the greatest and most beneficial results from individuals and combined effort at the lowest cost in dollars and human values. Objective management, combined with experience and training, will result in the development of co-ordination and good balance between the various responsibilities if you retain four basic factors: simplicity, flexibility of organization, complete co-ordination and co-operation. Remember, co-operation is not a one-way street.

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(concluded on page 82)



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Drawing Up an Organization Chart

MOST hospitals have organization charts; the purposes for which they were drawn up vary; the purposes for which they are currently used vary; the interpretation of these charts varies. If these charts were to be brought to your office and you were to examine them with two other administrators, the resulting discussion would be lengthy and lively. You might not be able to agree on what each one attempted to show and you might conclude that some charts entered the realm of myth—in comparison with the actual set-up of the hospital which they depicted.

Used in the discussion would be terms such as "line", "staff", "functional", "organizational structure", "organizational control", et cetera, all terms to be found in the standard texts on organization and management. These terms of course, you would understand, notwithstanding how loosely you used them, but they would possibly leave your group somewhat confused.

Some charts might be ones relegated, as a rule, to a practically inaccessible corner of the administrator's office; some might be those considered by the administrators to be the essence of their organization and to which all administrative problems were referred and thereby resolved. Others might be those used solely as a guide, with the knowledge of the limitations involved.

The object of an organization chart is that of showing the essential structure of an organization and depicting the basic relationships between the positions shown. It is essentially a graphic representation and should be a method by which all members of an organization can have explained to them their position in that organization. The drawing up of and the perusal of a chart by the administrator can provide him with a focal point of thought

Norman K. Barr,
Hospital Insurance Service,
Dept. of Health and Welfare,
British Columbia

when considering administrative problems.

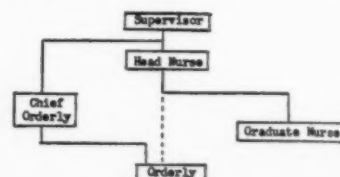
Some administrators try to show too much on a chart which ends up, on occasions, resembling a spider's web with straight lines, dotted lines and multi-coloured lines. Obviously an organization chart cannot show everything, but it is the writer's opinion that an attempt should be made to show the basic structure of the organization.

Basic Structure

The question arises then as to what is the basic structure of an organization. Avoiding, for simplicity, the use of academic terms, a readily understood chart can show either of two basic relationships, namely the "executive" or "disciplinary" one and the "work" one. The reason for using the two relationships above is that a hospital consists, in actual fact, of a myriad of relationships that render its comparison with an industry or an armed service quite difficult. If an attempt were made to depict the "line", "staff", and "function" relationship together with the control of an "area" or on a "function" basis, several charts would be required for the larger hospitals. These charts would be quite complex and their object lost, in all probability.

The "executive" relationship is that where an employee is responsible to his superior for matters relating to discipline or those other than professional matters; the "work" relationship is that where an employee is responsible to his superior for matters concerning the actual performance of his work. An example showing this differentiation is that found in the nursing department where, for instance, the "executive" re-

lationship is shown by a straight line and the "work" relationship by a dotted line:



The illustration shows particularly the orderly's relationship to the head nurse and the chief orderly. From the "executive" point of view, he is responsible to the chief orderly; it is the latter who will "hire" or "fire" him and to whom the orderly would go for personal problems. The orderly is responsible to the head nurse of his ward for the "work" relationship; the orderly should obey instructions concerning work from the head nurse.

It can be seen readily that the above example could become unwieldy if relationships between persons were shown for a typical nursing unit in a large hospital where there were orderlies, nurse aides, ward maids, ward clerks, practical nurses, and student nurses, each responsible to a superior other than a head nurse for non-nursing or "executive" functions. Under such circumstances it might be mandatory to have two charts showing the "executive" and the "work" relationships separately; this would certainly save a crossing of many dotted and solid lines.

It is natural when drawing up a chart that an effort be made to make it look reasonably tidy. In attempting to do this some points concerning the graphic representation of relationships are bound to turn up. Thus a number of queries may come to mind.

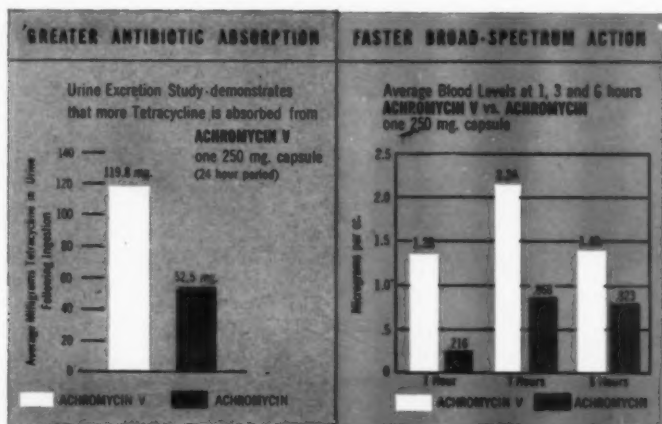
1. The following two representations are shown alternatively from time to time:

(continued on page 64)

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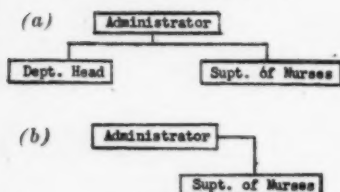
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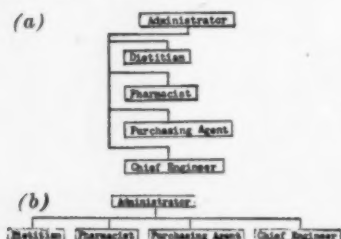
Organization Chart
(continued from page 60)



It is the writer's opinion that the above two diagrams should not be considered as alternatives. In as far as the superintendent of nurses bears an "executive" relationship to the administrator, diagram "a" would appear to be the correct representation. The writer feels that the executive relationship should be shown diagrammatically by the line extending from the bottom of one "box" to the top of the other. A line leading to the side of a "box" connotes an advisory relationship.

The point may seem a small one, but consistency does avoid confusion, especially when reference is made to the chart by those members of the staff filling junior positions.

2. Depending upon the layout of the chart, the following two representations are shown; these may be used alternatively to show the same relationship:



3. Another question which can arise is that of the different horizontal levels at which positions are shown on the chart. Often it is not possible to show positions of persons, at a similar work level in the organization, on the organization chart at the same horizontal level. For example, in diagram "a" above, the dietitian, pharmacist, purchasing agent and chief engineer are all department heads, but they are on a different level graphically. Attempts should not be made, therefore, to adhere to graphic levels representative of actual levels of persons in a hospital. In fact, it is the writer's opinion that a notation should be made at the bottom of a chart to the effect that position levels do

not indicate relative levels of importance or seniority of persons in the hospital, but show merely the relationship of any one person in the whole organization.

One problem that would appear to exist in the minds of some who draw up organization charts is that of the relationship between the board of directors, the administrator and the medical staff. Undoubtedly some charts show an organization which does not represent the true picture in the hospital which they depict. It is a problem that is not well understood by many or which, if understood, is tackled in a somewhat woolly fashion.

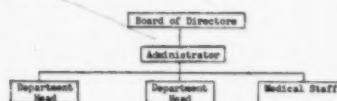
It is generally considered, in this country, that dual control is undesirable and that one person, the administrator, whether he be medical or non-medical, should be the chief executive carrying out the policies of the board of directors. For this reason, everything concerning the hospital should be dealt with by him alone and any action either up to or down from the board of directors should go through him.

The position of the doctor is unique. No administrator has any right to tell a doctor how he is to treat his patients and the position of the doctor as the head of the medical treatment team is in no way questioned. Non-medical and administrative questions involving the medical staff are, however, ones involving the administrator. When a board decides that the medical staff should organize itself, that decision should be implemented through the administrator whose position would be that of "getting the ball rolling". This requires tact, since the medical staff should organize themselves and, having done so, should govern their own activities within the framework of the hospital's constitution and by-laws, rules and regulations.

Where there is a hospital regulation stating that a "consent for operation" form should be completed prior to surgery, such a rule should be enforced by the administrator. He would be within his rights to order the cancellation of an operation where such a form was not available prior to an operation and where a surgeon was preparing to operate under such circumstances.

With this in mind the following diagram would represent the

relationship among the three groups:



The above example is one shown in its simplest form. However, it may be desired to show, when such exists, where the joint advisory committee or medical board fit in. The joint advisory committee consists generally of an equal number of board members and doctors, with the administrator as the secretary. The committee does not have any executive function but it does afford a means of contact between the medical staff and the board of directors. The joint advisory committee may be shown on the chart as follows:



It is usual for the administrator to be secretary of this committee. In this example it can be seen that the advisory relationship among the board of directors, joint advisory committee, and medical staff is shown by lines extending to and from the sides of the "boxes".

The executive relationship drawn down from the board of directors through to the administrator to the medical staff represents the line of authority taken when decisions reached at the joint advisory committee are effected by the board of directors.

Medical Staff

The medical staff must be a self-governing group but their activities must come within the framework of the hospital's constitution and by-laws. If the administrator, as the executive head of the hospital, is to succeed, the board of directors cannot expect to by-pass him when dealing with the medical staff. Whether there be a joint advisory committee, a medical board or a representative of the medical staff on the board of directors, this contact should be only in an advisory capacity, with the administrator represented, in each case, probably as secretary. Any decisions reached by the board of directors, who are

(continued on page 106)



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Medical Records in a Military Hospital

THE criterion of such a course should be the benefit derived by the student and the hospital which employs the student. The purpose of this article is to outline the knowledge gained by this student and how the teachings of the course were put into effect at his hospital.

The student was one of a small group sponsored by the Department of National Defence and accepted for the course which commenced in September, 1955. At the time of acceptance the student was the non-commissioned officer in charge of the admitting office of the Kingston Military Hospital. This hospital is operated by the Canadian Army for the Department of National Defence, through the medium of the Royal Canadian Army Medical Corps.

The application of the mechanics of a medical records department to this military hospital proved to be an excellent test of the effectiveness of the course. The reason for this statement is that a military hospital is required to submit all original hospital clinical records to army headquarters at Ottawa. There was no medical records department, in the true sense, in existence at the hospital at that time.

It was decided at the beginning of the course to apply each phase of the course to the hospital as the student made progress on the lessons. This decision was reached by the Area Medical Officer (whose capacity might be compared in some respects with that of a chairman of the board for a civilian hospital) and by the Commanding Officer (comparable to administrator) of the hospital.

The first step that was taken was the adoption of the centralized unit system for the filing of records and

Sgt. M. A. Williams,*
Kingston Military Hospital,
Kingston, Ontario

method of reference. The acceptance of this system met the requirements of our medical staff to have in-patient and out-patient records kept in chronological order on one file for each patient. It was then necessary to institute a control of clinical and out-patient documents as they entered the records department. This was effected by initiating the receipt of a daily roll of admissions and discharges from the admission office and a daily roll of attendance at the out-patient department. Unit numbers were recorded opposite the patient's name. These were later checked off in red when the papers were received in the records department.

When it was found that the centralized unit system was operating smoothly and to everyone's satisfaction, it was agreed to initiate the quantitative analysis. It will be appreciated that our quantitative analysis must be exact as we are required to prepare copies of records that we wish to retain on file. It was considered that this would be the appropriate time to organize a Medical Records Committee within the medical staff of the hospital. A chairman was appointed together with a representative from medical and surgical services. The student was detailed to act as secretary of this committee. The meetings of the committee were necessarily burdened with much administrative detail at its inception. A permanent minute book was instituted and minutes of each monthly meeting were passed to the Commanding Officer for his consideration. All recommendations of the committee were later reviewed by meetings of the Execu-

tive Committee of the medical staff at the hospital. The requirements for copies of clinical records which were to be kept on our files were carefully considered. It was decided that the component parts of our clinical record for filing would consist of history sheet, consent for operation, operation record, anaesthetic record, pathology report and treatment record. In order to obviate reproducing copies of laboratory and x-ray reports it was agreed that such reports could be typed onto our copy of the history sheet. Deficiency slips were taken into use to return charts for completion. A daily routine of checking late reports prevented undue delay of our charts.

Nomenclature

The adoption of the *Standard Nomenclature of Diseases and Operations* was the next phase, with the medical staff agreeing to use the Standard terminology when recording a diagnosis. The student did not endeavour to code the diseases and operations until several coding exercises had been submitted with his lesson assignments and the results had been received. When coding was commenced the student was the fortunate recipient of the full co-operation of the medical staff, which was of inestimable aid to him.

With the introduction of coding the next step was to establish disease and operation indices. The method of Dual Grouping by Topography and Etiology or Procedure was recommended by the Medical Records Committee and approved by the executive committee of the medical staff.

A modified version of the Monthly Analysis of Professional Services was taken into use, which was adapted to the requirements of a military hospital. The statistics afforded proved to be of interest to the various medical services of the hospital.

In summary it can be said that the teachings of the course were of great assistance to the student and his hospital. By application of the methods and routines that were taught, a medical records department has been organized and operated to the benefit of the patient, hospital and medical staff. The Canadian Hospital Association and the Canadian Association of Medical Record Librarians are to be congratulated on a fine educational program which is contributing to the betterment of medical records in Canadian hospitals.

* The author is a student medical record librarian.

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◀ Correspondence ▶

Question Still Debatable

To the Editor:

I read with much interest the article by Dr. G. W. Peacock and the letter from Dr. Harvey Agnew in the April issue and it encouraged me to submit an additional point or two on the "Debatable Question" of "Practising Physician as Board Member".

When a hospital board grants a permit to a doctor to practise medicine in that hospital isn't he in the same position as other persons with whom the hospital has a contract? Should a person with a contract have a vote in the management? To my knowledge this practice is considered unethical and more often than not it is prohibited by law.

The hospital administrator and other executive hospital staff would find it most embarrassing, I feel, to have to be concerned or deal with requests from a doctor who is not only a member of the medical staff but has a vote in regard to his or her salary and status of appointment.

I feel that it is surely a fallacy to assume that, in order for the board to obtain and make use of valuable advice, it becomes necessary for the medical man to be given power toward enforcing the

advice he gives. If this is true and this argument is valid, then the board of governors would not be made up of lay people but would be composed of professional and technical experts and trained hospital administrators.

To co-ordinate, to integrate efficiently the work of many persons trained in various fields of endeavour is really the main function of a hospital board. This is done so as to provide the best patient care. Board members should not usurp the function of competent professional staff.

No one will argue when we say that in every hospital there should be harmony and mutual confidence between the doctors practising in the hospital and the Board. The advice of doctors and of all professional personnel in all lines of work is essential to efficient management. Does it follow, however, that by giving votes to persons with specialized training in medicine we achieve the best? Doctors already have complete control of the practice of medicine in their hospital and this is a practice in which a hospital is not legally allowed to indulge.

(signed) (Mrs.) Marie Chandler,
Chairman, Trustee Division, British Columbia Hospitals' Association.

Environmental Disease Panorama Resulting from Industrialism

The past and continued introduction of numerous new chemical and physical pathogens into the human environment due to the advent and growth of modern industrialism has resulted in the appearance of many environmental diseases non-existent before this era. The study and identification of the pathological manifestations associated with and characteristic of these diseases and the determination of the specific causal agents represent an important and urgent task facing the medical profession in general, and pathologists in particular.

Because of the limited number of reaction mechanisms at the disposal of the human organism and of the dependent restricted types of pathological reaction products, some of the environmental diseases elicited by the new pathogens mim-

ick symptomatically and pathologically some infectious diseases. The most important health hazards created by exposure to the new environmental pathogens are related to repeated and prolonged contact to relatively small doses which do not elicit any dramatic immediate symptoms but which produce chronic degenerative diseases sometimes appearing after a long period of delay free from any significant symptomatic reactions.

Perhaps the rather recent extinction or near-extinction of several species, such as the passenger pigeon, the whooping crane, the buffalo, and the great auk, which apparently could not successfully adjust themselves to new environmental conditions, may help us to realize that also the survival of man depends upon his successful adaptation to environmental conditions.



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◀ Provincial Notes ▶

Yukon

At the beginning of this year a new 16mm projector was obtained by the Yukon Film Society. This machine will remain at the Whitehorse General Hospital for entertainment of the patients.

British Columbia

A 125-bed addition to Burnaby General Hospital, Burnaby, has been proposed as the first stage of a master plan to eventually increase hospital facilities to 600 beds. A new 32-bed hospital at Castlegar has been planned by architects Paul D. Smith and A. Wheatley, Trail. Associate architects are Williams and Fairbank, of Nelson. The estimated cost is \$522,000.

A new nurses' residence at Chilliack General Hospital will accommodate 30 nurses in a two-storey frame structure. Architects are Thompson, Berwick and Pratt, Vancouver, who have also designed a 35-bed addition to the hospital. The latter will be a four-storey reinforced concrete structure, and will bring the total capacity to 140 beds. The total estimated cost of the addition and new residence is \$1,375,000.

Extension of the Kitimat temporary hospital, designed by Architect J. Russell Baxter, has been completed and will provide the town with more than 65 beds until the proposed new hospital is ready.

Architects Alan Gray, Stilwell and Lobban, Vancouver, are working on plans for a 17-bed hospital and an adjoining nurses' residence at Lillooet. It will be a single-storey reinforced concrete fireproof structure with partial basement. Services will be provided for a maximum of 30 beds and provision will be made in plans for eventual expansion to 50 beds. Architects for a \$50,000 nurses' residence at Vanderhoof are Gardiner, Thornton, Gathe and Associates, Vancouver. The two-storey and basement frame structure will accommodate 14 nurses. Construction was scheduled to start in June.

The provincial government proposes to erect a 600-bed mental hospital on Vancouver Island. A \$599,423 construction contract has been awarded to Sorenson Construction Co. Ltd. of Vancouver, for building a 70-bed chronic-care hospital for children in Vancouver. It will be an addition to the Vancouver Preventorium. Construction of a \$1,000,000 maternity wing is planned by St. Joseph's hospital, Victoria. Plans have been started by Architects Whittaker and Wagg. The proposed wing would contain 84 beds.

Alberta

The new five-unit Banff Mineral Springs Hospital is taking shape steadily. Although it has the same number of beds (45) as the existing hospital, the facilities of the \$700,000 building will be considerably increased.

Work was scheduled to begin this spring on a 40-bed addition to the Providence Hospital in High Prairie at an estimated cost of \$800,000.

The Rimbey Municipal Hospital board is working on plans for an addition of 14 beds, alterations, equipment and the construction of

a nurses' home at an approximate cost of \$225,000. McKernan and Bouey, of Edmonton, are the architects.

Saskatchewan

Construction of a hospital at Hudson Bay, to a maximum of 14 beds, has been approved in principle. Also, plans are being prepared by Architects Kerr and Cullingworth, Saskatoon, for alterations and extensions to the Lashburn Union Hospital. The 16 by 40 foot extension will be a single-storey frame structure with a stucco exterior finish and will contain a nursery, out-patient room and new operating theatre.

Construction should soon get under way on the new ten-bed hospital proposed for Milden. Architects are Webster and Gilbert, Saskatoon. The same architects were engaged to draft plans for an extension to the Paradise Union Hospital at Paradise Hill. The extension, to provide facilities for five additional beds, operating and case room, additional toilet and bathrooms and nursery, will cost an estimated \$33,000.

The Saskatchewan Government has authorized grants totalling \$153,839 for hospital improvements in the province. Of this amount, \$55,086 has been granted to Swift Current Union Hospital, Swift Current, to assist in a program of renovation and construction of a three-storey extension to the present hospital, to add 41 more beds to the present 114-bed capacity. An additional \$39,000 was granted to assist in construction of a 78-bed nurses' residence. The whole project is expected to cost \$500,000.

St. Walburg Union Hospital board of directors will receive \$13,136 toward construction of a ten-bed hospital. St. Joseph's Hospital, Ile à la Crosse, has been granted \$46,617 for construction of a building to house an additional 35 treatment beds as well as service facilities and staff quarters.

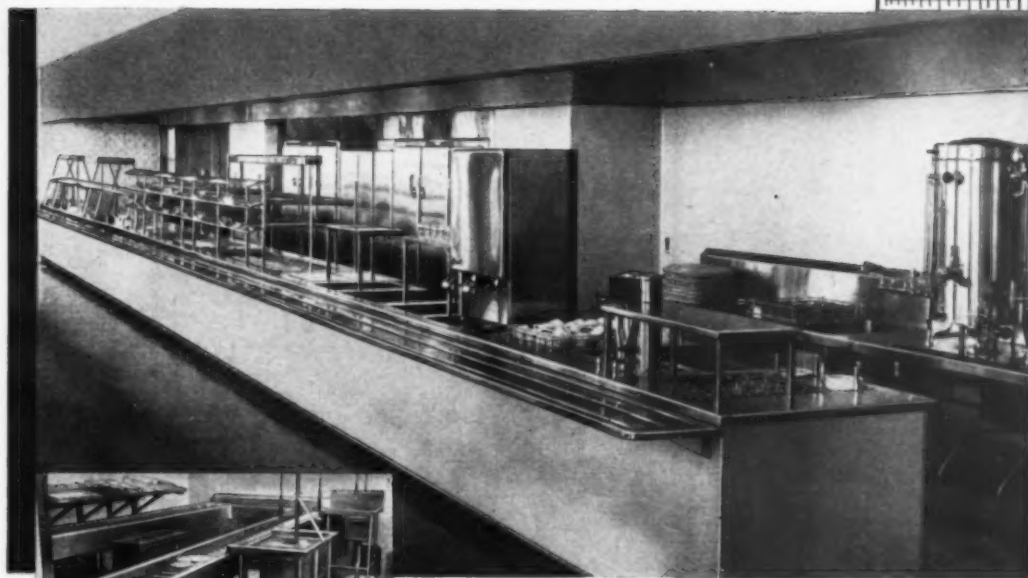
Construction of a nurses' residence is planned by the board of Rosthern Union Hospital, Rosthern. Plans are now underway to increase the size of St. Therese Hospital at Tisdale, and provide further area for laboratory, isolation, administration and out-patient service. At Wilkie Union Hospital, Wilkie, a new 200 ma. diagnostic x-ray unit and a new mobile 90 ma. unit have been installed.

(continued on page 88)

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Public Relations Institute

APRIL 15th and 16th saw the first Public Relations Institute held under the joint sponsorship of the Ontario Hospital Services Commission and the Ontario Hospital Association in Toronto, Ontario. Official greetings were extended at the opening session by C. V. Charters, president of the O.H.A., and Arthur J. Swanson, chairman of the Commission.

As first guest speaker, Byrne Hope Sanders, formerly editor of *Chatelaine*, in assessing the importance of public relations in the hospital field, pointed out that public relations starts with the board of directors and goes right down through the staff; that good staff relations come from a sense of identification, as employees want to be part of the dreams and ambitions of the organization. In conclusion, Miss Sanders added that the modern hospital has lost the gloom of the earlier hospital and that today the hospital problem is not only to get people well, but to keep them well.

Charles S. Watson, public relations and advertising consultant

for the Drug Trading Company, Toronto, was the second speaker on Monday morning. "There is need in your field of public relations for understanding and sympathy in association with your public", Mr. Watson informed the hospital people, in his effort to define "public relations".

A panel discussion between hospital representatives and news media representatives, entitled "Two sides to every story", took place on Monday afternoon. Priscilla Campbell, former superintendent of the Public General Hospital, Chatham, and a member of the board of directors of the O.H.A., expressed the belief that hospital people must take news reporters into their confidence. "Each hospital should maintain some plan of bringing the press together with the hospital. I would suggest that you invite the city editor and news reporters to take a tour of the hospital, and introduce them to the heads of the hospital and the board of trustees", Miss Campbell said.

Sidney Liswood, of New Mount Sinai Hospital, pointed out that

there are three sides to every story, the patient being a very important third party. He continued that the hospital had no right to release information without first getting the patient's approval. Mr. Liswood held the view that the press should give young administrators time to clear information with the patient and his family. In 99 cases out of 100, there would be no difficulty.

Arthur Cole, city editor of *The Telegram*, drew attention to the problem of a recent case of the patient celebrity. "There was no source of news except through the surgeon in charge. The doctor in this case was very co-operative, but also very busy. The hospital should have made arrangements to put out bulletins through the day". Mr. Cole suggested that the hospitals empower more people to give out information to the press.

Tuesday morning was devoted entirely to a workshop session in which all delegates were given an opportunity to discuss four PR problems. All problems came under the subject, "Building a public relations climate", and included community, employee, patient, and medical staff relations.

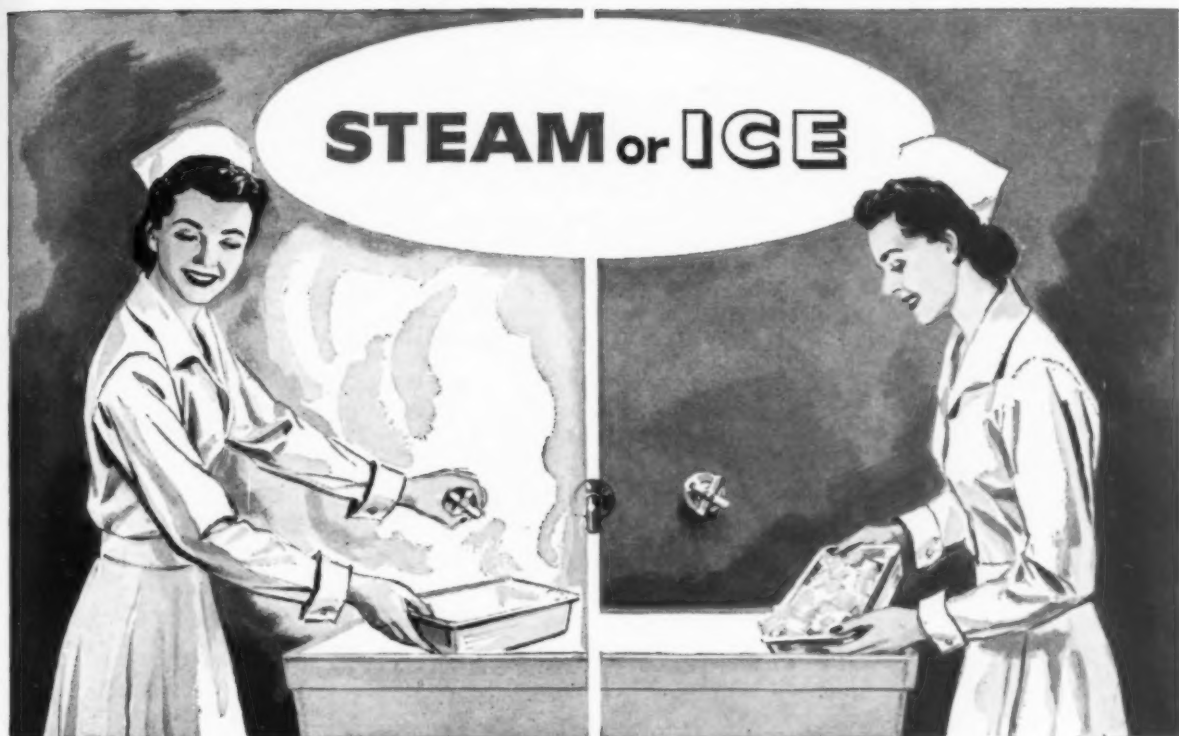
In addressing Institute delegates on the rôle of the Association in assisting member hospitals, Stanley W. Martin, executive-secretary-treasurer of the O.H.A., said that one of its major functions is to provide a voice for hospitals which can be heard at provincial and federal levels. He felt that hospitals' concern over various problems will be welcomed by governments so long as it is reasonable and enlightened. Mr. Martin stressed the need for hospitals to maintain proper contact with the many professional associations and organizations represented in the hospitals' personnel structure. This is necessary in order to provide hospitals with the opportunity to inform these groups on hospital problems and, at the same time, furnish a means by which the hospitals can learn the problems faced by these professions.

Mrs. J. Buchan, president of the Women's Hospital Auxiliaries Association of Ontario and second speaker of the afternoon, informed the delegates that her Association today provides hospitals with over 41,000 goodwill ambassadors. In commenting on citizen participation in the hospital field, she said that auxiliaries serve hospitals in three ways—by raising funds, establishing public relations and by volunteer services.

(concluded on page 90)



Among the participants were Dr. Marshall McLuhan, Toronto, C. V. Charters, Brampton, and the Rt. Rev. J. G. Fullerton, Toronto.



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You Were Asking...

Several administrators in hospitals of 100 beds and under in size were invited to answer the following question: *What is your procedure regarding administrative coverage when you are not at the hospital?* The answers received are as follows.—*Edit.*

*St. George's Hospital,
Alert Bay, B.C.*

THE important rule seems to be "Leave a note of where you will be, whether for a matter of an hour or a month".

After office hours administrative coverage is undertaken by the supervising nurse, who has direct contact with the administrator by telephone.

Weekends, daily coverage is made possible through the administrative office or that of the matron.

Holiday periods are covered by the matron who is always given the administrator's town or holiday phone number, while the office is still controlled by the accountant. In practice, the direct phone is used about once weekly; and phone requests on holidays up to a four weekly period, perhaps twice.

The system of well delegated duties during the normal work routine has proved itself during periods of absence.—*W. C. Deadman, Administrator.*

*Bassano Municipal Hospital,
Bassano, Alta.*

WE CALL this a 30-bed hospital because it has a complement of 25 beds and cribs and six bassinets. Whenever it is possible to do so, I keep a staff of five graduates and four registered nursing aides. I do my very best to see that all of the staff members are instructed in the handling of the autoclave and the water sterilizers, preparation of operating room materials, taking and processing films in the x-ray room and making all routine and simple laboratory tests.

I consider myself to be, and in fact am, on call 24 hours a day for seven days in the week. If I am absent from the hospital and still in town, the senior graduate on duty knows where to locate me by

telephone and I am consulted quite frequently in that way. There is no thought of appointing any person as my deputy, but the senior graduate on duty during my absence from the hospital is considered in charge. If I have to leave town, of course, some other arrangement is made but so long as I am in town I want to know what is going on at the hospital.—*(Mrs.) Margaret Hislop, R.N., Supt.*

*Grande Prairie Municipal Hospital,
Grande Prairie, Alta.*

I DO NOT believe that there is any necessity, even in a small hospital, to live, quite literally, with your work. In this hospital, very few occasions arise when it is necessary to call the administrator or the matron after six o'clock in the evening.

The night staff are perfectly capable of carrying out the admitting routine and they take care of all ordinary emergencies. No one is specifically detailed to assume the responsibility. They know my telephone number of course, but I have not had a call in months.

It is my opinion that the type of administrator who lives with his work is one who dislikes to delegate any authority, under the impression that it would detract from his own.—*M. G. Stanton, Sec.-Treas.*

*Dauphin General Hospital,
Dauphin, Man.*

I CONSIDER it a serious error to have the administration of an institution so wrapped up in one person that when he is not available there is no one who can make decisions.

In our hospital there is some member of the office staff on duty between 7:00 a.m. and 11:00 p.m. every day of the week. These people have been thoroughly instructed in admitting and discharge procedures, et cetera. If I am away during the day the director of nurses acts in an administrative capacity.

When neither the director of nurses nor I are on duty the ad-

ministrative responsibility falls on the evening or night supervisor as the case may be. These positions are filled by registered nurses who are fully orientated in their duties and responsibilities.

With this administrative set-up it is only on odd occasions that it becomes necessary for me to be called. It is only when I leave town that instructions are left at the hospital as to where I can be reached.—*A. J. Schmiedl, Sec.-mgr.*

*York County Hospital,
Newmarket, Ont.*

REGARDING administrative coverage, I would say it has not been too great a problem with us. I have a full-time assistant who had excellent experience in a large hospital and therefore is quite capable of assuming full responsibility when I am off duty. We are rarely both away from the hospital during the day; and we work on alternate week-ends and statutory holidays in order to give complete coverage. We are always available by telephone but are rarely called after hours.

The charge nurses in the case room on the evening and night shifts are both familiar with the hospital and are quite capable of handling most problems which might arise.—*Lillian E. Thomas, R.N., Supt.*

*Hôpital Jean-Talon,
Montréal, P.Q.*

L'ADMINISTRATEUR d'un petit hôpital doit vivre plus près de son institution que tout autre car son budget ne lui permet pas d'obtenir des assistants. Il lui faut cependant prendre le repos nécessaire pour mener son oeuvre à bonne fin.

Durant les veillées, les nuits, et les fins de semaines, l'infirmière surveillante en charge remplace l'administrateur pour les affaires de routine. Cependant, celui-ci reste toujours accessible par téléphone. S'il devait s'absenter il laisserait le détail de ses allées et venues. Toutefois, cet arrangement n'est pas l'idéal. Actuellement, je prévois l'organisation théorique et pratique d'un système de relève. Il me semble que tous les chefs de département (qui sont peu nombreux) devraient faire partie de l'arrangement de façon à ce que la continuité soit assurée et que l'ad-

(continued on page 104)



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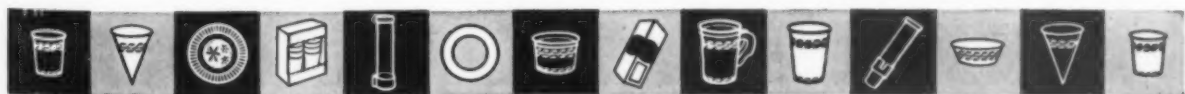
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With the Auxiliaries

Active Auxiliary at Chesley

The Women's Auxiliary at Chesley and District Memorial Hospital, Chesley, Ontario, have recently finished installing a large clothes dryer in the laundry department at an approximate cost of \$1000. With their main source of revenue coming from a Monster Fall Bazaar, they have also provided the hospital with a new dishwasher, linens and other small purchases amounting to \$3,100.

Saskatchewan Activities

The Hospital Helpers of Watson Union Hospital, Watson, Sask., have planned their annual picnic for June 23 which will be held in connection with a bazaar. Recently, this auxiliary presented a cheque for \$883 to the hospital to cover all outstanding accounts.

Meanwhile, the Women's Auxiliary of Central Butte Union Hospital, Central Butte, Sask., decided to buy an ultra-violet lamp, a swivel chair for the laboratory, and two blinds for the hospital dining room by way of equipment.

Cheque for Hospital Equipment

A cheque of \$1,260 was presented to Sister Mary Albert, Superior of St. Mary's Hospital, Inverness, N.S., by the president of the Ladies' Aid to pay for the portable x-ray which was recently installed in the hospital.

Unique Fashion Show

The Ladies' Auxiliary of St. Martha's Hospital, Antigonish, Nova Scotia, recently presented a fashion show of native Indian costumes owned by Antigonish residents and acquired in India. Mrs. John Wayling assisted in explaining where each costume originated, what type of material was used and to which class of people each belonged.

Forty local ladies modelled the costumes on the stage of the Parish Centre, which was suitably decorated with Indian brass work and silks. Attire included wedding dress as well as work and formal costume. Onlookers were also entertained with the performance of

authentic native dances of India by two daughters of members of the auxiliary.

Busy Auxiliary at Lachine General

The 75-bed Lachine General Hospital has the distinction of having the largest Women's Auxiliary on a patient-auxiliary member ratio of any hospital in Canada. A new height in hospital occupancy at this hospital in Montreal, P.Q., brought an 83 per cent increase in work done by the auxiliary sewing and supplies committee. Their main project and most successful from a fun-raising point of view is the "Good-As-New-Shop" which showed a net profit of \$6,158 during the past year.

Auxiliary Member Honoured

In a short ceremony during the annual meeting of the Women's Auxiliary to Victoria Veterans' Hospital, Victoria, B.C., a life membership was conferred by the retiring president on Mrs. W. G. Colquhoun. Active in the work of the auxiliary during the nine years it has functioned, Mrs. Colquhoun was one of the founders, temporary chairman at the inaugural meeting and named first president of the group.

Hot Meals

Hot meals are now guaranteed for patients at Civic Hospital, North Bay, Ontario, thanks to the latest addition to the hospital's kitchen, a new \$3,000 stainless steel hot plate pellet oven which was recently presented by the Ladies' Auxiliary. They have raised funds to donate this and many other items of equipment to the hospital and are presently holding a membership drive in North Bay.

Quebec Convention

The Province of Quebec Association of Hospital Auxiliaries held its fifth annual convention on March 12th in the Convention Hall of the YWCA in Montreal. The rôle of the auxiliary in a program of mental hygiene education provided the general theme of the convention and among the guest speak-

ers were Dr. G. D. Griffin, General Director of the Canadian Mental Health Association, and Dr. Gaston Gauthier, clinical director of the Children's Aid of the juvenile court of Montreal. An active president, Mrs. Sylva Lamothe, was newly elected as well as vice-presidents, Mrs. Alton Goldbloom, Mrs. Wilder Penfield, Mrs. J. B. Handfield, Mrs. M. H. Lacoste, and Mrs. K. E. Norris.

Fashions for the Housewife

A display of new fashions for the average housewife's budget was shown to local women in the Spring Fashion Show sponsored by the Ladies' Auxiliary of Western Memorial Hospital, Corner Brook, Newfoundland. A sum of \$834 was realized by the auxiliary and the two-hour show included approximately 110 different ensembles, some of which catered to the teenage and small fry sets. Eight novelty prizes were presented following afternoon tea.

This auxiliary has also recently donated \$1,000 to the hospital for the purchase of a new operating room light.

Auxiliary's Library

The hospital library sponsored by the Women's Auxiliary of the New Mount Sinai Hospital, Toronto, Ont., is reported to have had a turnover of 3,000 books and 15,000 magazines during the last year. Books are taken on a day-to-day basis by the patients and also changed every three months. The library includes material in ten languages.

A Chemical Analysis

An invitation to dinner had been sent to the newly settled physician. In reply the hostess received an absolutely illegible note.

"I must know if he accepts or refuses," she declared.

"If I were you," suggested her husband, "I should take it to the druggist. Druggists can always read doctors' letters, however badly they are written."

His wife followed his advice. The druggist looked at the slip of notepaper, went into his dispensary and returned a few minutes later with a bottle, which he handed over the counter.

"There you are, madam," he said. "That will be seventy-five cents."

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University of Toronto Students in Hospital Administration

Shown here are the 1956-57 students and members of the staff, Department of Hospital Administration, School of Hygiene, University of Toronto. Having completed the academic year of this post-graduate course, the students will spend the next 12 months in administrative residencies at hospitals in Canada or the United States where arrangements have been made for their further instruction.

In the back row, from the left: Dr. J. K. Morrison who will study at Westminster Hospital, London, Ont., under the preceptorship of Dr. E. A. Fergusson; Dr. J. V. Roberts, who goes to Shaughnessy Veterans' Hospital, Vancouver, B.C., under Dr. T. D. Bain; R. I. Crickmore, Kaiser Foundation Hospital, Vallejo, California, under Vernon Brammer; and K. S. McLaren, Toronto East General Hospital, under Eric R. Willcocks.

Third row, left to right: Dr. A. W. Taylor, Toronto General Hospital, will study under Dr. J. E. Sharpe; Dr. B. L. P. Brosseau goes to Sunnybrook Veterans' Hospital, under Dr. C. MacLeod; Dr. Richard E. Builder, Humber Memorial Hospital, Toronto, Ont., under R. B. Ferguson, and R. A. Hudon will be at Kitchener-Waterloo Hospital, Kitchener, Ont., under Walter Hatch.

Second row left to right: W. H. Schofield goes to Mercer Hospital, Trenton, N.J., under Charles Stewart; H. A. Spencer to Ottawa Civic Hospital, under Douglas R. Peart; J. W. Short, Royal Jubilee Hospital, Victoria, under George E. Masters; and Dr. J. P. McCabe, to Sunnybrook Veterans' Hospital, under Dr. C. MacLeod.

In the front row are members of the staff: Robert B. Ferguson, Special Lecturer; Dr. G. Harvey Agnew, Professor and Director; Eugenie M. Stuart, Associate Professor; Harold Dillon, Research Fellow; and Dr. W. Douglas Piercey, Assistant Professor.

Administrative Ideal (concluded from page 58)

beyond our control as individuals have forced us to concentrate upon group relationship. Hence, we have been so busy with group negotiations, contracts and all the other procedures and red tape involved that we tend to lose sight of one all-important elementary fact. No two individuals are alike, no two have the same needs, wants and ambitions—each has his own peculiarities, self-expression, feelings, virtues, and shortcomings. I must repeat that, when mutual respect, confidence and over-all understanding exist between those who labour and those who manage, such relationships cannot help but be excellent.

The fine art of the executive administrator in making decisions consists in refraining from: deciding upon questions that are not pertinent; deciding prematurely; making decisions that cannot be made effective; and making decisions that others should make. Today our hospital stands, a very complex organization, for the restoration and maintenance of health—with trained employees, modern

sciences of medicine and specialized scientific equipment—all of which depends upon groups of people working together in a situation where each individual must contribute to performance of tasks as well as planning activities, and daily human relations.

Time

Hospital administrators must be allowed the time to follow proper management procedures. I am sure all are anxious to do so if given the opportunity. Failure to use good basic techniques is bound to be costly at any time, but particularly so when hospitals are facing a real challenge. This in my opinion, they will do during the next decade which promises to be a trying one for all hospitals in Canada. Some of us, especially in British Columbia, are already into a period of change, with the introduction of the 40-hour work week and sharply increasing wage rates. Who can say what effect automation will have on employment concepts before too long? The entire basis of hospital operations and controls will undoubtedly be considerably, or even drastically, changed with

the introduction of a federal hospitalization scheme.

You all know how the introduction of new products and the changes in medical science have affected, and will continue to affect, hospitals. The list is endless. Only executives with the knowledge and the time and ability to use good administrative procedures can keep up with, and apply to the best advantage, the changes as they develop. Failure to do so will mean that your hospital will not be giving the type of care your public has a right to expect.

I would like to close on this thought (from "The Salutation of the Dawn", from the Sanskrit):

*Look to this Day!
For it is Life, the very Life of Life.
In its brief course lie all the Verities
and Realities of your Existence:
The Bliss of Growth
The Glory of Action,
The Splendor of Beauty.
For Yesterday is but a Dream,
And To-morrow is only a Vision:
But To-day well-lived makes every
Yesterday a Dream of Happiness,
And every To-morrow a Vision of
Hope.
Look well therefore to this Day!*

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Notes on Federal Grants

Construction

Federal support has been approved for improvements in accommodation at Shaunavon, Lloydminster, Weyburn and Coronach. The Saskatchewan Hospital at Weyburn is to receive a total of \$47,000 in connection with the provision of 94 beds in its nurses' residence with construction of an additional floor. At Shaunavon Union Hospital, a grant of \$3,500 will assist with the cost of space for seven nurses' beds and a suite for a matron. Alterations at Lloydminster Hospital, adding three beds to its capacity, will be facilitated by a \$1000 federal grant, and \$3000 have been allotted to the Coronach Union Hospital to help meet the costs of a nurses' residence.

St. Mary's Hospital, New Westminster, B.C., has received a federal hospital construction grant of more than \$163,800. The grant will be used to help meet the construction costs of a new 160-bed hospital, with modern medical, surgical, obstetrical and paediatric facilities to serve more than 130,000 people in New Westminster and district. It is anticipated that the present hospital will be demolished when the new building is completed early in 1958.

Mental Health

A sum of \$7,575 will be contributed to research at the University of Western Ontario, London, on the development and outcome of mental illness. In this study the principal investigators are Professor G. E. Hobbs, head of the university's department of Psychiatry and Preventive Medicine, and Dr. Carol Buck, associate professor. They will be assisted by two psychologists. Their investigations will be directed towards two aspects of mental disease—its cause and background and activities relating to recovery and rehabilitation.

Research at the University of Toronto, Ont., to determine the range and frequency of hereditary characteristics of certain types of mental defectives has also been supported by grants. It is believed that the results will have practical application in diagnosing such defects in the newborn child. The

investigation, to be made by Dr. N. F. Walker, Associate Professor of Human Genetics in the university's department of Zoology, will receive a \$3,600 grant.

A third mental health grant of \$3,401 goes to the University of Toronto's study of the personality traits of certain types of sex offenders and other cases, including neurotics and psychotics, referred to the Toronto Psychiatric Hospital. This research will be directed by Dr. K. G. Gray, Associate Professor, Department of Psychiatry, University of Toronto, who will have as associates the chief psychologist at the Forensic Clinic, Toronto Psychiatric Hospital, and a research assistant.

Research

Diagnostic, treatment and research facilities of the Montreal Children's Hospital, Montreal, P.Q., are to be extended with the aid of grants totalling nearly \$29,000. A cancer clinic there will be supported by a cancer control grant which will go towards the part-time salaries of an assistant pathologist, an x-ray therapist, an x-ray technician and a physicist, and to the cost of x-ray equipment to be used for deep and superficial therapy of malignant tumors. Establishment of research facilities in its child health program in the Montreal area will be aided by the contribution of \$13,900 for the purchase of technical equipment for the department of Experimental Paediatrics of this hospital.

Establishment of a glaucoma clinic at the Winnipeg General Hospital is to be assisted by a National Health Grant to extend the chain of such important centres in Canada's blindness control program. Glaucoma clinics are already operating in Saint John, N.B., Montreal, and Quebec, P.Q., Toronto, Ottawa, and London, Ontario, and Vancouver, B.C. A general public health grant of \$8,455 will enable Winnipeg General Hospital to study cases of glaucoma from its out-patient department and hospital wards, as well as those referred to it by ophthalmologists. The clinic will be held one-half day per week, its personnel consisting of a

director, who is a certified oculist, a nurse and a medical social worker, on a part-time basis.

Research in connection with physico-chemical studies related to "dehydration fever" and to surgery in the first few weeks of a baby's life, being carried on at the University of British Columbia, will receive \$3,635 in grants. The work will be directed by Dr. J. F. McCreary, head of the department of Paediatrics at U.B.C., and will be carried on by research specialists in the newborn nurseries of the Vancouver General Hospital and the wards and research laboratories of the Health Centre for Children.

Grants amounting to \$7,675 for research are intended to aid in reducing the risk of death or the development of cerebral palsy or mental deficiency following breathing difficulty at birth. This work will be carried on under the direction of Dr. Sidney Segal, director of research and his assistants at the Health Centre for Children. One phase of the research, the development of a method of determining blood pressure in newborn infants, will be carried on by Dr. John Dean of the U.B.C. department of paediatrics.

Free Transfusions at Toronto Hospitals

A free blood transfusion service to patients in the hospitals of Metropolitan Toronto was assured last month in a joint statement by Norman C. Urquhart, C.B.E., Chairman of the Hospital Council of Metropolitan Toronto, and Marshal Stearns, M.B.E., Chairman of the National Executive Committee of the Canadian Red Cross Society. An agreement has been reached whereby the Canadian Red Cross Society will provide blood to all Toronto Hospitals, commencing January, 1958.

A nominal service charge will be made by the hospitals to cover equipment, laboratory and administrative expenses in connection with the actual transfusion. Blue Cross subscribers, those covered by Workmen's Compensation, or patients having other forms of prepaid hospital care, will, of course, have the service charge paid on their behalf where it is covered under the respective contracts of the plans concerned.

In order to assure a constant supply of blood, the Canadian Red Cross Society must, in the interim, launch an intensive recruitment campaign for blood donors.

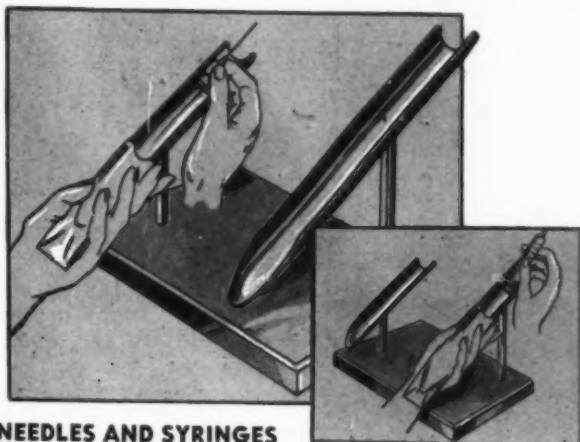
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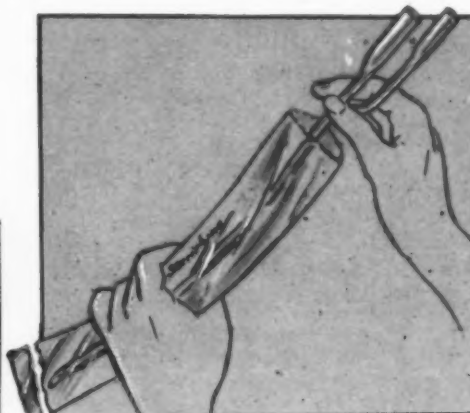
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Dishwashing Machines

PRIOR to 1944 there was no common meeting ground for representatives of the dishwashing machine industry and public health officials. When the industry considered new models or the redesign of existing models, international acceptance was an immediate major concern. When problems were discussed with various public health officials, we seemed to always turn up with as many answers as the number of health officials contacted.

During 1944, the National Sanitation Foundation, a non-profit organization with headquarters at the School of Public Health, University of Michigan, was organized. The N.S.F. charter provides for a broad consideration of the problems of public health and environmental sanitation. It charges the trustees with the obligation of approaching solutions through research and development. Here at last, we felt, was the answer to one of our major problems.

Immediately after the founding of the National Sanitation Foundation, development research programs were started and one of the very first was the testing of commercial dishwashing machines. These research findings were published in bulletin form and were widely distributed.

Research bulletin No. 1 was published in October 1947, and contained a complete research study on the sliding-door, single-tank, stationary rack, spray-type, dishwashing machine. Research bulletin No. 2 was published in August 1949, and contained a study of single-tank, spray-type, automatic rack-conveyor type dishwashing machines, with final curtain rinse. Though a considerable amount of ground was covered in bulletins No. 1 and No. 2, all phases of dishwasher testing have not been completed.

**The author is Sales Manager, Hobart Manufacturing Company, Limited, Toronto. This article is reprinted with permission, from the Canadian Journal of Public Health, Feb., 1957.*
***For references see end of article.*

H. C. Pharoah,*
Toronto, Ont.

In June 1948, a dishwashing panel was formed. Health officials and industry assembled for the purpose of discussing and recommending certain procedures. These recommendations are contained in the 1948 Clinic Report.^{(1)**} This was the first time in the history of the dishwashing machine industry that people of national repute, representing health officials and industry, sat down at a conference table and discussed their mutual problems on a national basis. Not only were these problems discussed, but definite recommendations were formulated.⁽²⁾

The clinic and research work previously done by the Foundation by no means completed the work. It was necessary that the multiple-tank spray-type, automatic rack-type machines, with final curtain rinse, be tested. When this work was completed, the National Sanitation Foundation published a single bulletin, containing in condensed form, a summary of the findings and the further research being carried on at that time.⁽³⁾ All the findings were based on research work.

It is recognized that industry's part in the National Sanitation Foundation is not all there is to the problem of clean dishes, but the industry is vitally interested in this co-operative effort with public health.

Dishwashing machines are produced in a wide range of sizes to suit the various types of operations. There are four well-defined groups.

Group 1 consists of small stationary-rack, door or rolling-hood type machines. The smallest unit in this group is a front-door opening, undercounter or free standing unit. It is a small unit usually installed in front or back bars of taverns for glass washing, in soda fountains for glass and mixed dishwashing, hospital diet kitchens, decentralized washing in small hospitals or in small restaurants for

mixed glass and dishwashing, where the customer count per meal does not usually exceed 50 persons. The medium-size machines in this group are revolving-hood, telescopic-hood, sliding or rolling door models. These are usually installed in small establishments, except that larger models increase the capacity to provide for customer counts up to 125 persons per meal. The largest size of machines in this group is the vertical, sliding-door unit, constructed for either straight through or corner installation. This machine is normally installed for centralized mixed dish or glass washing where the establishment has a customer count of up to 250 persons per meal. These models constitute approximately one-third of all of the dishwashing machine units produced today.

Group 2 consists of the single-tank, automatic rack-conveyor with curtain-type rinse. This is produced in both the small and medium sizes with a re-circulated pumped wash solution and a final curtain rinse. This type of machine is second in popular demand and is normally installed in dish pantries for centralized mixed dishwashing in medium-size establishments. The smaller size unit has a capacity to handle dishes for approximately 300 to 400 persons per meal while the medium size units will provide capacity for 400 to 600 persons per meal.

Group 3 consists of multiple-tank, automatic rack-conveyor types with final rinse. These machines are constructed with two or more units built into the same housing and are therefore high capacity machines. They are constructed with a re-circulated pumped wash, a re-circulated pumped rinse and a final hot water curtain rinse. They are usually produced in three sizes to provide ranges of capacities of from 500 to 1,200 persons per meal, depending on the installation and type of service.

Group 4 is a relatively new addition to the dishwashing machine

(continued on page 109)

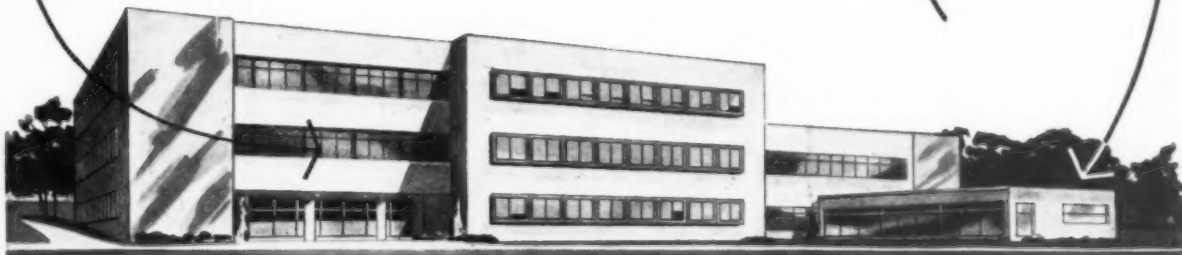
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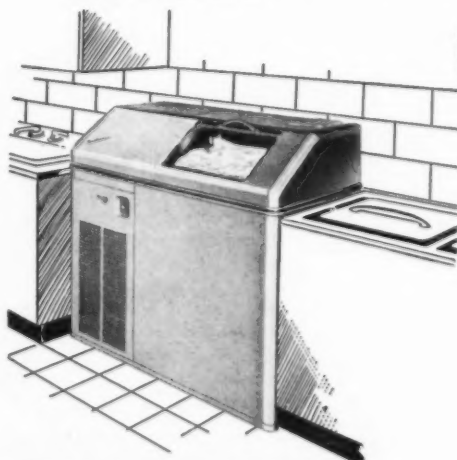


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Model SF-75WSA



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Provincial Notes
(continued from page 72)

Manitoba

The new "inclusive" rate plan for hospital services went into effect in all Manitoba hospitals commencing Monday, April 1st, on recommendation of the Associated Hospitals of Manitoba, following lengthy study. The rates include payment for ordinary general duty care, ordinary drugs, labora-

tory requirements, x-ray, delivery room, operating room, anaesthesia, transfusion and oxygen services. A small list of expensive drugs and other personal services will be charged to patients, but generally all ordinary hospital care will be covered in future by the inclusive rate.

Ontario

Plans have been accepted for a new \$700,000 wing for the Cobourg

General Hospital, Cobourg, to be of brick, concrete, and steel construction, with 106 beds. Architects are Drever and Smith, Kingston.

Three new mental hospitals for children are to be built in western Ontario at a cost of \$16,000,000. One 1,200-bed hospital will be constructed about midway between London and Windsor. A second unit, of 600 beds, will be built in the Georgian Bay area and the third, also 600 beds, will be in the centre of the Huron, Perth, Wellington and Waterloo area.

Demolition is now under way in the first of three stages of a re-modelling project planned for the Ontario Hospital on Lake Shore Road, New Toronto. New kitchen and staff dining facilities will be provided in the central building.

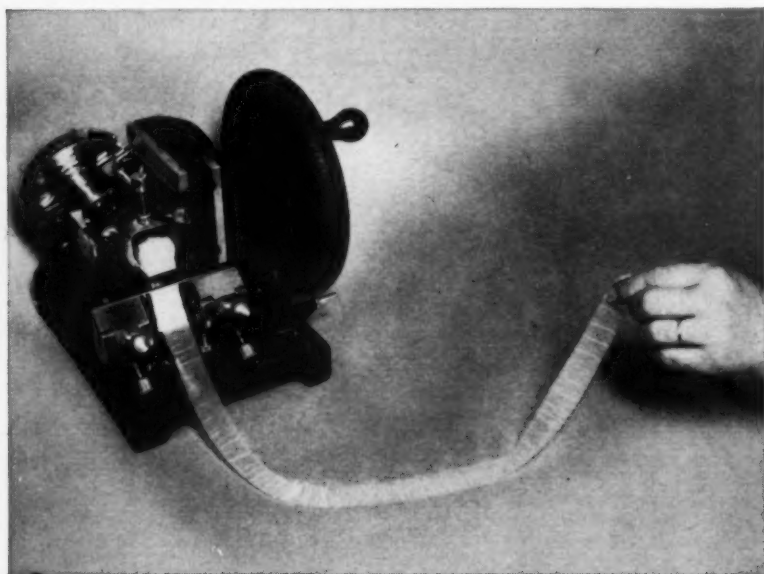
A proposed Welland-Crowland hospital, to replace the present Welland County Hospital has been planned for 300 beds with allowance for vertical expansion on the main wing to permit an extra 200-bed addition. Construction may begin this fall.

The first all-obstetrical hospital to be built in Canada will be the new Grace Hospital of the Salvation Army. It will cost more than \$2,000,000 and will be completed in 18 months. The six-storey hospital, which is to be built in Toronto, of red brick and stone trim, will have accommodation for 125 adults and 88 infants. Architects are Govan, Ferguson, Lindsay, Langley and Keenleyside.

Expanded facilities and services at Brockville General Hospital, Brockville, will include a four-storey west wing and a two-storey east wing. In addition, the nurses' residence will be increased to more than double its present size to accommodate the staff needed to operate the larger hospital. The provincial government has approved the plan in principle and will confirm grants as soon as a current appeal for \$399,000 in funds has been answered.

A \$3,000,000 addition to St. Mary's Hospital, Kitchener, to provide accommodation for another 150 beds is being considered by the advisory board. This would relieve serious overcrowding at the present hospital.

Officials of South Huron Hospital, Exeter, are planning expansion through addition of a wing to the southeast portion of the present building, construction of a nurses' (concluded on page 90)



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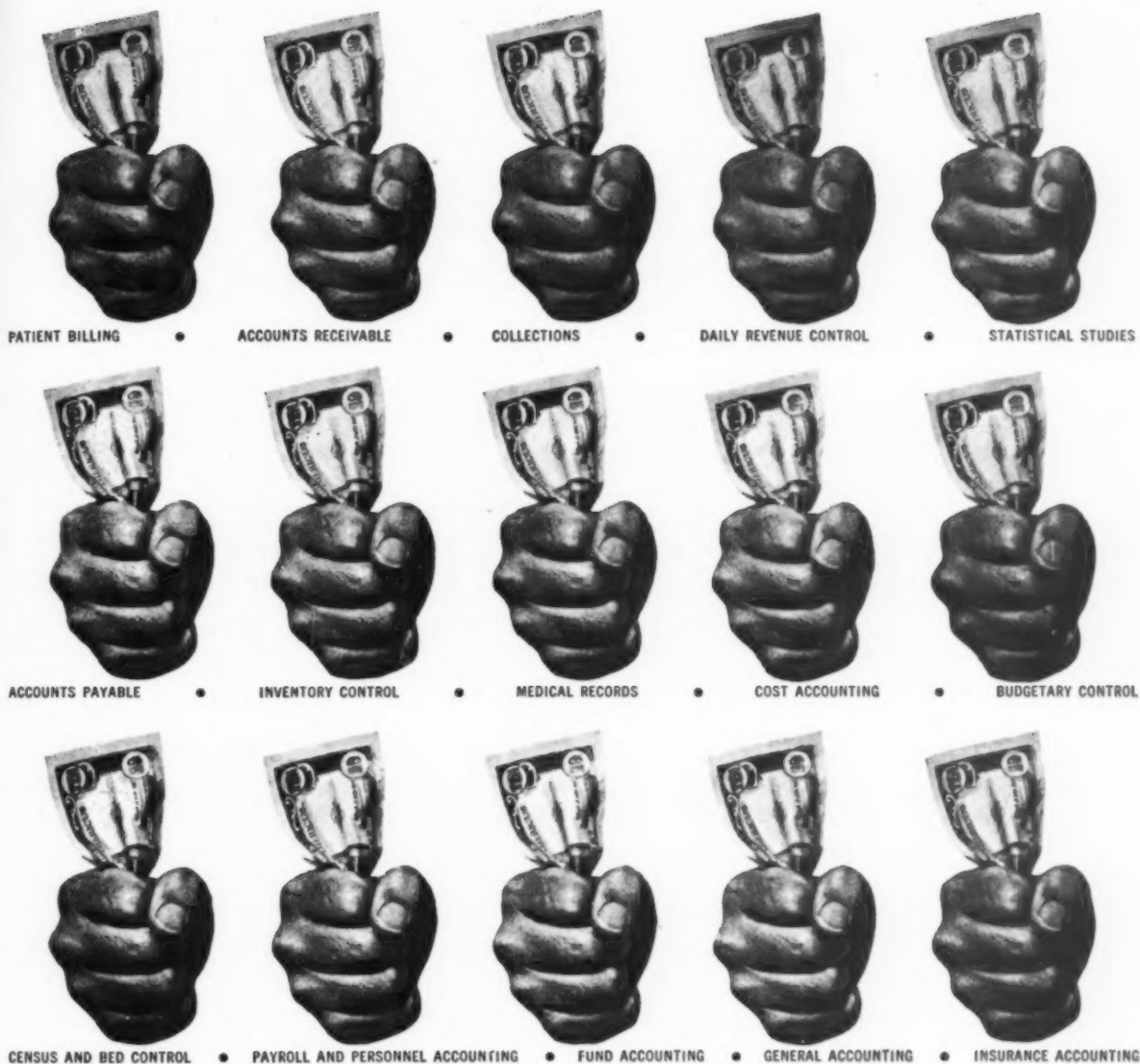


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Provincial Notes

(concluded from page 88)

residence opposite the hospital, and increased operating room facilities.

When completed early in 1958, the South Peel Hospital, Port Credit, will have accommodation for 120 adults and child patients and 33 babies, besides providing all the essentials of a metropolitan hospital.

Quebec

Preparation for expansion of Quebec City's oldest hospital—300-

bed Hotel Dieu—included modernization of the existing laundry. New laundry is now in operation. The hospital is now midway through a five-year building project which will entail an expenditure of ten million dollars, and the erection of a 13-storey addition. From present size of 300 beds, the hospital plans to go to 500.

New Brunswick

Work is progressing well on hospital extension and renovation projects in Campbellton, Chatham,

and Tracadie. An \$875,000 extension to Hotel Dieu de Saint-Joseph in Campbellton is expected to be completed by the end of 1957. This will bring this hospital's capacity to nearly 240 beds. An extension to Hotel Dieu de St. Joseph in Chatham should be completed by the end of September, raising the capacity of this hospital to slightly over 200 beds. Almost completed is a renovation project at Hotel Dieu in Tracadie to provide additional hospital beds. Bélanger and Roy, Moncton, are architects for these three projects.

Nova Scotia

Modern and adequate facilities for obstetrical care are provided in the new wing of the Grace Maternity Hospital, Halifax. The old building will be renovated in the near future to provide an additional 34 beds. At Windsor, a new heavy-duty rotating anode tube has been installed in the Payzant Memorial Hospital.

Prince Edward Island

Construction has been started on the new wing of the Prince Edward Island Hospital at Charlottetown. The structure is expected to cost \$744,000.

Public Relations Institute

(concluded from page 74)

The third speaker of the afternoon was Kenneth C. Cross, director of public relations for the O.H.A., who discussed public relations as tools and techniques. He said that it was best to keep three basic principles in mind in public relations when planning a program or dealing with the public at any time: to inform, to inspire, and to show consideration.

Evaluation questionnaires which were filled out and submitted by the delegates after the institute indicated general satisfaction with the program as such. In many cases it was felt that the problems and solutions discussed were not sufficiently applicable to the smaller hospital. A majority of answers, however, spoke of the assistance and ideas afforded by this meeting in the problem of improving public relations in the hospital field.

Things printed can never be stopped; they are like babies baptized, they have a soul from that moment, and go on forever. — Meredith.

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The third edition of *Hospital Organization and Management* by Malcolm T. MacEachern is now available. The book has been completely revised and the content has been extended considerably over the second edition published in 1946. It has been printed by Physicians' Record Company, Chicago, Ill., U.S.A. Price \$18.75. A review of the new edition will appear in a later issue of this journal.

SELECTED PAPERS OF HAVEN EMERSON. Published by the W. K. Kellogg Foundation, Battle Creek, Michigan, U.S.A. Price \$3.00 Pp. 507.

"Most of the articles reprinted in this book were spoken or written to meet a particular request or situation rather than as parts of a

connected body of thought or sequence of personal inquiry", writes Haven Emerson in the preface. However, these 35 papers not only reflect the varied activities of the author as epidemiologist, statistician, and leader in the field of public health in their subject matter, but also convey a vivid impression of a keen mind and forceful personality.

In the preface of the book Dr. Emerson provides the reader with a summary of his experience in the field of medicine and related activities. This short personal review conveys the spirit and style of the articles which follow as well as introducing the reader to the personality and interests of the writer.

"There have been the several settings for work and a way of life: General medical practice, 1899-1913; teaching physiology, physical diagnosis, and clinical medicine in the wards, a happy

period of great satisfaction and the intimacies of families of patients. A plunge into public life, 1914-17, as Sanitary Superintendent and then Commissioner of Health of New York City, adaptation to the rigidities and compulsions of civil government, frustrations and accomplishments alternating. This was an experience in democracy as a platform from which to sell the wares of human biology, an apprenticeship in the school of practical politics for a novice in public health.

"Army service, 1918-19, where every experience in medicine and administration was tested in the crucible of sudden and vast emergencies of war, a period of concentrated discipline with the inevitable loss of self-direction for a purpose set by others.

"University career, 1920-1940, to establish and develop the component of public health in the teaching of medical students and for graduates in public health, with the indispensable field practice of civil health diagnosis or surveying, consultation, and public speaking, to gain experience and apply academic
(concluded on page 98)

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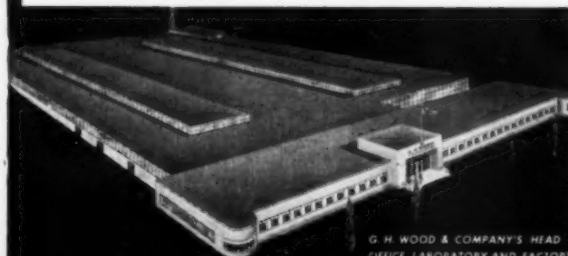
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over losses to a minimum. This is but one of 12 favourite Heinz Soups—each offering you a similar low portion cost! See your Heinz man and start saving on your food bills.

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Twenty Years Ago
(From *The Canadian Hospital*,
June, 1937)

It is reported that, at a meeting in St. Louis recently, members of the American College of Physicians witnessed the demonstration of a new x-ray machine, which "sees through" bones and takes accurate cross-sections of any tissue of the body at any depth, or "makes possible what has hitherto been impossible", to quote Dr. Sherwood Moore of the Edward Mallinckrodt Institute of Radiology. This is ap-

parently accomplished by focusing the rays to any designated depth, thus eliminating the shadow of the superimposed or underlying tissues.

The American College of Surgeons held its second Sectional Meeting in Canada this year at Halifax, on May twentieth and twenty-first. The program with different speakers was substantially the same as at Edmonton. In carrying out the clinical program the Dalhousie Public Health Clinic, Grace Maternity Hospital, Children's Hospital, Victoria General Hospital and Halifax Infirmary

participated. The Nova Scotian Hotel provided commodious space for all the other activities of the conference. About two hundred and fifty physicians and hospital executives attended and it is estimated that at least one hundred and fifty more attended for part of the time who did not register. . .

British Columbia—At the forthcoming provincial election on June the 1st a plebiscite will be taken on the desirability of provincial health insurance. The Health Insurance Act of 1936 was not put into operation because of the opposition of various groups in the province. Whether or not the Liberal party, if re-elected, will reintroduce a modified health insurance measure will depend upon the result of this plebiscite. . . .

St. Boniface, Man.—Enterprising bandits have discovered a new use for hospitals. Two robbers, who had "cleaned up" \$16,000 in cash in four quick payroll robberies in Winnipeg, took refuge in St. Boniface Hospital, where they were admitted complaining of abdominal discomfort. Placed in adjoining beds, their identity was not suspected until after their recovery, when they did another \$10,000 payroll job, and the memory of a taxi-driver established their identity; each got 7 years.

As soon as finances will permit, a \$50,000 hospital is to be erected at South Porcupine, Ontario. Tisdale Township Council has voted \$15,000 towards the project.

A grant of \$5,000 has been obtained from the government for an extension to the Mater Misericordiae at Rossland, B.C.

Erection of a 20-bed Lacombe (Alta.) and district community hospital was recommended recently by a committee which had been appointed to investigate and report to the town council and the council of the municipality. Contributions to the cost of the building are proposed on the basis of one-third by the town and two-thirds by the municipality, each to do its own financing. A board of five members, two for the town and three for the municipality will be appointed to manage the hospital.

Building operations, estimated at \$75,000, will be commenced shortly at St. Joseph's General Hospital at Comox. An extra storey will be added to the existing building, and a new three-storey addition with basement will be constructed of frame and brick veneer.

A Beautiful Book about Beautiful Bed Signs



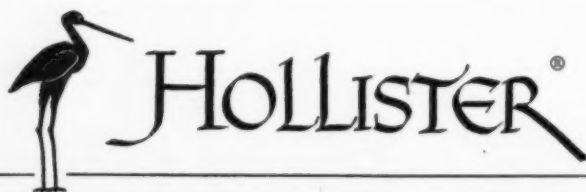
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New, non-cycling refrigeration unit holds temperature inside the hood to within one degree at all times. Humidity is equally stable. The refrigerating unit runs continuously, eliminating "on-off" switching that disturbs the patient and causes temperature variation. Larger, slow-speed blower provides ample circulation at a lower noise level.

Model Twenty-Five is available in three frame heights to accommodate all commercial bed rails. This compact, lightweight unit is mounted on a SterilBrite® frame with 4" ball-bearing conductive casters for greater mobility.

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Book Reviews (concluded from page 92)

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- June 12-14—Canadian Dietetic Association, annual meeting, Chateau Frontenac, Quebec, P.Q.
- June 17-21—Canadian Medical Association, annual meeting, Macdonald Hotel, Edmonton, Alta.
- June 17-21—A.H.A. Nursing Service Administration Institute, Chateau Laurier, Ottawa, Canada.
- June 18-21—Maritime Hospital Association, annual meeting, Algonquin Hotel, St. Andrews, N.B.
- June 21-22—Canadian Association of Physical Medicine and Rehabilitation, fifth annual meeting, Royal York Hotel, Toronto, Ont.
- June 24-26—Comité des Hôpitaux du Québec, convention-exhibition, Montreal Show Mart, Montreal, P.Q.
- June 25-28—Canadian Tuberculosis Association, annual meeting, Vancouver, B.C.
- July 14-19—Fifteenth annual Accounting Institute of the American Association of Hospital Accountants, Indiana University, Bloomington, Indiana.
- August 11—Canadian Society of Hospital Pharmacists, annual meeting, Montreal, P.Q.
- Aug. 26-28—Maritime Conference of the Catholic Hospital Association.
- Sept. 29—American College of Hospital Administrators, annual convocation, Convention Hall, Atlantic City, New Jersey, U.S.A.
- Sept. 30-Oct. 3—American Hospital Association, annual convention, Hotel Traymore, Atlantic City, N.J.
- Oct. 15-18—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.
- Oct. 22-24—Associated Hospitals of Alberta, convention, Provincial Auditorium, Edmonton, Alta.
- Oct. 28-30—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.
- Oct. 31-Nov. 1—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.
- Nov. 11-15—Institute on Housekeeping, King Edward Hotel, Toronto, Ont.
- Nov. 14-15—Operating Problems of Small Hospitals, Bessborough Hotel, Saskatoon, Sask.

Canadian Association of Physical Medicine and Rehabilitation

The fifth annual meeting of the Canadian Association of Physical Medicine and Rehabilitation, is being held June 21 and 22 this year, in the Royal York Hotel, Toronto, Ont.

Among topics scheduled to be discussed by noted speakers are the following: "Management of Spasticity in Paraplegia" by A. T. Jousse, Toronto; "The Training of Rehabilitation Personnel", by G. Gingras, Montreal, P.Q.; "Rehabilitation in Manitoba", by M. H. L. Desmarais, Winnipeg, Man.; "Common Problems in Geriatrics and Rehabilitation", by L. Cosin, Oxford, England; and "Senile Rehabilitation Program at the Jewish Home for the Aged, Toronto", to be

treated in a panel discussion led by H. Silverstein, Toronto.

Guest speaker at dinner June 21st will be M. Carl Walthard, of Geneva, Switzerland.

Hospital Opens Nursery School

A New York hospital has come up with an idea calculated to help to combat the shortage of nurses.

The Montefiore Hospital has opened a nursery school on the hospital grounds for the children of nurses, bolstering its staff by 17 trained nurses who otherwise would be home minding their children. A laboratory technician and the nursery school director also take advantage of the school. Since nurses must be on duty by 8 a.m., breakfast is served at the school, the only nursery school to do this.

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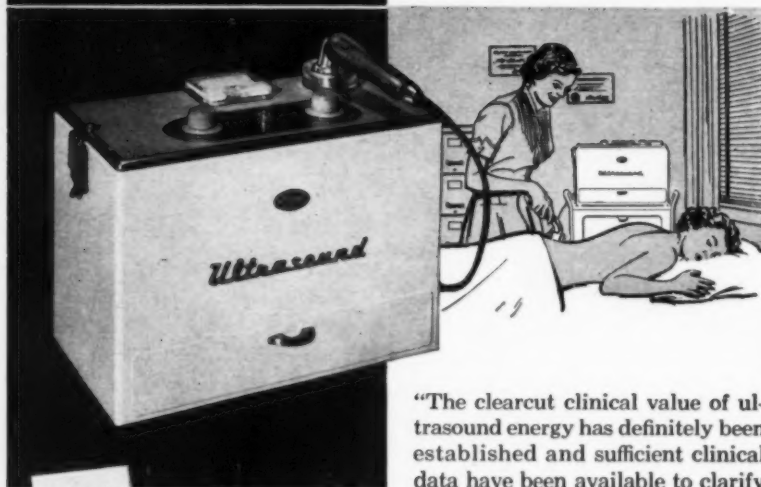
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*Phillips, K., et al: J. Florida M. Assoc. 43:341 (Oct.) 1955

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Notes About People

(continued from page 28)

Hospital as well as three years' service with the Royal Canadian Army Medical Corps.

Her appointment becomes effective in September. The pilot project is expected to extend over a period of two years.

To Visit Medical Schools Abroad

Dr. Robert M. Janes, Toronto, has been appointed a Sims Commonwealth Travelling Professor of Surgery for 1958 by the Royal College of Surgeons of England. Dr. Janes, who is head of the University of Toronto's Department of Surgery and surgeon-in-chief of Toronto General Hospital, will visit medical schools and universities in Jamaica, West Africa, South Africa and East Africa.

New Specialist at Lafleche Hospital

Dr. Richard Dessureault has recently been appointed to head the laboratory department at Lafleche Hospital, Grand'Mere, Quebec. After graduating from Laval University in 1948, Dr. Dessureault continued his medical studies as an intern at Laval Hospital, Quebec, and later (1952-1954) at the Metropolitan Hospital, Bellevue Hospital and New Rochelle Hospital, New York. He is a certified specialist in pathology.

Grand Manan Hospital Appointment

The Grand Manan Hospital, at Grand Manan, N.B., is to have a new superintendent in the person of Freda Apt, R.N., who at present is on the staff of Kings County Memorial Hospital, Montague, P.E.I. She assumes her new duties June 15th and succeeds Mrs. Elizabeth Bass, R.N., who has been acting superintendent for some time past.

● Dr. R. Clarence Young of Pictou has been appointed medical superintendent of the Point Edward Hospital, Sydney, N.S. He succeeds Dr. S. J. Shane who resigned in February to accept an appointment with Dalhousie University and the City of Halifax as medical superintendent of the Halifax Tuberculosis Hospital.

● Clarence J. Wight has been appointed secretary and bookkeeper at Cardston Municipal Hospital. He took over his new duties April 15th, filling the vacancy left by the late William Montgomery.

The CANADIAN HOSPITAL

● Dr. Jack McKenty of Winnipeg was named president of the College of General Practice of Canada at its recent meeting in Montreal. New president-elect is Dr. P. B. Rose, Edmonton.

● Dr. L. J. Quinn has been named obstetrician and gynaecologist-in-charge at St. Mary's Memorial Hospital of Montreal, Montreal, P.Q.

● Miss I. Magnuson has replaced Matron Jean Nichol at Shaunavon Union Hospital, Shaunavon, Saskatchewan.

● W. S. Shields has succeeded George Hatt as business manager at the Queens General Hospital, Liverpool, Nova Scotia.

Radiation Treatment

Persons exposed to an overdose of ionizing radiation in war or industrial accidents may eventually be treated by a transplant of bone marrow which would enable them to manufacture healthy blood cells again.

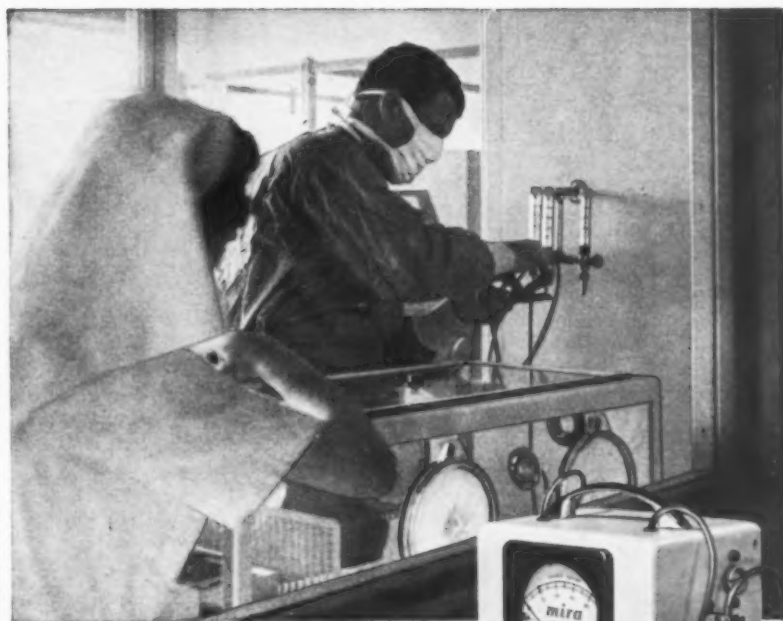
Marrow transplants have been carried out successfully on a small scale in both animals and humans, Dr. Shields Warren, Harvard pathologist and adviser to the U.S. Atomic Energy Commission's biology and medical division has reported.

Speaking at the fifth Military Medico-Dental Symposium in Boston, Mass., Dr. Warren said that he foresaw the possibility of setting up a marrow bank, from which supplies of healthy marrow could be obtained for transplants, after the fashion of blood banks and bone banks.

Marrow cell transplants are still highly experimental, he said, but could be invaluable in war or industrial accidents. Damaged cells would be washed out of the bone and replaced by healthy stored cells. He believed transplanted cells might function for several weeks in storage.—reported by David Spurgeon in *The Globe and Mail*.

Post-Graduate Course

The decision to organize a post-graduate course for nurses for advanced study in paediatrics was announced recently by Jean Masten, superintendent of nurses, at the graduation exercises of the Hospital for Sick Children School of Nursing, Toronto. The three-month course beginning in September will be a clinical supplement to the 12-week basic course in paediatrics.



Prevention OF RETROLENTAL FIBROPLASIA

Leading ophthalmologists believe that rigid control of the administration of oxygen can prevent RLF in newborn babies. They recommend, among other precautions, that oxygen be prescribed and measured in concentrations rather than flow rates, and that oxygen analyzers be made standard equipment in nurseries.

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You Were Asking
(continued from page 76)

ministration devienne l'affaire d'une équipe et non d'un seul homme. Il reste nécessaire que l'administrateur soit totalement informé des événements survenus durant son absence. Voilà l'importance du rapport systématique.

Translation

THE administrator of a hospital of 100 beds or under literally lives within his institution more than any other; the budget does not permit him to have assistants.

However, he has to have regular respite to be able to conduct his work successfully.

Therefore, during evenings, nights and week-ends, the nurse supervisor in charge covers the administrator's duties. He is, however, always available to her by telephone. If he is to be away he informs the hospital of his whereabouts. Nevertheless this arrangement is not ideal. Therefore I am at present studying the organization of a rotation service in the administration. The heads of the various departments should become partners in this team work as the

administration of a hospital is no longer a one-man task.

A systematic report to the administrator should give him all the data of current and special events which have occurred during his absence.—*P. E. Olivier, Comptroller.*

Shriners' Hospital for Crippled Children, Montreal, P.Q.

IT IS the policy in all Shriners' Hospitals "that there shall be an assistant director and/or a director of nursing service, who shall be instructed by the director in all duties pertaining to hospital administration, and shall be responsible for the affairs and conduct of the hospital in the absence of the director. Either of these persons shall be available for duty at all times".

Vacations, statutory holidays, week-ends, et cetera, are not taken at the same time as the assistant director and/or the director of nursing service.

When leaving the hospital, the director advises the person in charge when she will return, and if away for any length of time, where she will be, and how she can be contacted. However, it is only in a real emergency that it would be necessary to call her. When planning to be out of the city, the director tries to arrange that heads of all departments are on duty. In the evening and at night the senior member of the nursing staff is responsible, with the privilege of calling either of the above persons if required.—*Flora M. Lamont, Reg. N., Director.*

The Charlotte County Hospital, St. Stephen, N.B.

I AM ON call around the clock. After normal business hours administrative responsibility is delegated to the senior nurse on duty. If some unusual situation develops, which is not often, I can be located by phone.

When I am out of town the procedure is that any special emergency be referred to an officer of the executive board. The arrangement is not too satisfactory, but under the circumstances, it is difficult to do otherwise.—*K. E. Irvine, Administrator.*

Morden District General Hospital, Morden, Man.

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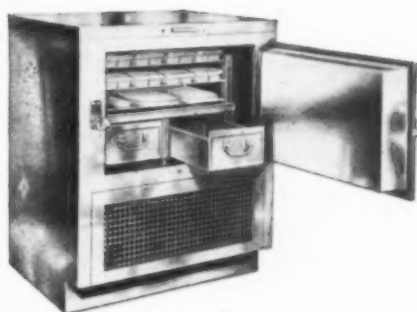
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Organization Chart
(continued from page 64)

the ultimate body for reaching decisions, should come through the administrator. The board must, however, retain such basic governing functions over the medical staff as admission or dismissal of doctors to or from the staff, together with limitations of privileges.

Although of different composition, the medical board can have a similar relationship with the board of directors, but again it can only be in an advisory capacity. It is a practice in some hospitals (and a legal requirement in one province) for a member of the medical staff to be a member of the board of directors. Many are the arguments both in favour of and against this arrangement; and several articles have been written recently covering this point. Nevertheless, the executive action should come through the administrator and should not be made directly between the board of directors and the medical staff.

The medical staff in the hospital are in a unique position for they are heads of the many teams car-

ing for the patient. It is they who direct the care which a patient is to receive from the professional standpoint. Emanating from the medical staff are the "work" relationship lines and although not shown on the chart they do exist at all times, e.g., when a doctor prescribes a treatment for a patient to the head nurse. To try to relate the medical staff to the rest of the organization would involve again many lines and produce a very cumbersome chart.

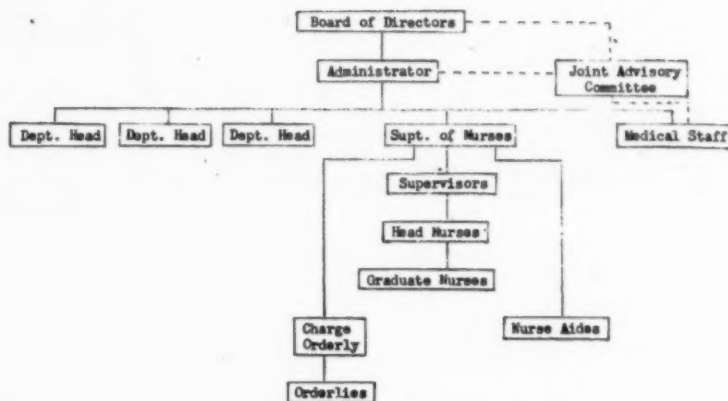


Figure 1

The other relationships on the chart should be fairly straight forward, provided that not too much is shown. It is the writer's opinion that the main organization chart should be one showing the "executive" relationships. The chart down here, fig. 1, with detail only of the nursing department, is an example of a fairly common type of organization.

In the above example, only four department heads have been (concluded on page 108)

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Organization Chart
(concluded from page 106)

drawn in; the number would, of course, depend upon the size of the hospital and on the degree of departmentalization. In a small hospital the superintendent of nurses will often be found assuming the position of assistant or deputy administrator. It will be noted that the chart is drawn up in terms of people. It is important that there be consistency in this respect and that there should not be a mixture of persons and of positions as, for example, where for departments there are: purchasing agent, engineer, and pharmacy, the last one being inconsistent with the first two.

It might be desirable to draw up a chart showing the "work" relationships in a hospital. This could be drawn up with the concept of teams in mind.

It is the writer's opinion that copies of the organization chart should be available to everyone in the organization or should at least be posted where ready reference to them can be made. There would be a value to having a detailed breakdown of organization for each department, the main organization chart being in general terms. The value of such a departmental chart would be greatly enhanced by a written explanation such as could be provided in a personnel manual. Much can be done during the employee's induction period to provide him with a sound knowledge of his working relationships and responsibilities within his organization.

It is of the utmost importance that an organization chart be reviewed from time to time. It should be changed if necessary, for an organization is rarely static.

The chart is no panacea for curing the administrator's organizational ills, but like a ship's compass, it can do much to indicate in which direction he is heading and in helping him to interpret his organization to his staff.

Expedient

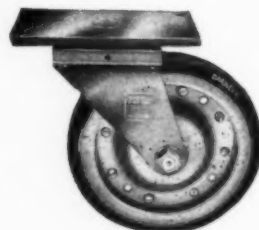
A passenger in a friend's car was impressed with the courtesy of the chauffeur who was driving him out to Long Island. "I notice you stop to let pedestrians cross the Parkway," approved the passenger. "It's better than hitting them," explained the driver, "because then you gotta fill out endless forms and reports."
—*Kitimat Northern Sentinel.*

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Dishwashing Machines
(continued from page 86)

field. This is the inclined-dish, spray-type conveyor unit, which might commonly be termed "continuous racking". It is a multiple-tank unit, through which passes a conveyor constructed with inclined wire loops or nylon pegs. Dishes are inclined at an angle on the conveyor similar to normally racked dishes. These units usually consist of a re-circulated, pumped water-scrapping section, re-circulated pumped wash section, a re-circulated pumped rinse section and a final hot water curtain rinse. These are high capacity machines and are built in sizes suitable for handling dishes from a service of 700 to 3,000 persons per meal.

One of the most important phases of good dishwashing is proper layout. Many times the layout is directly affected by the space available, but every installation should be planned to properly care for as many as possible of these basic operations.

Sufficient soiled dish loading space should be provided. A quick drain across the full width of the soiled dish table, with a removable strainer should be inset into the table immediately adjacent to the dishwashing machine. This drain prevents the entrance of liquid soil into the dishwasher.

Removal of Unconsumed Food

There are several methods of scrapping from which to choose. A rubber scrapping block, with waste-can below for disposal of unconsumed food waste is frequently used. Better results are obtained by water-scrapping which is usually achieved by one of four methods.

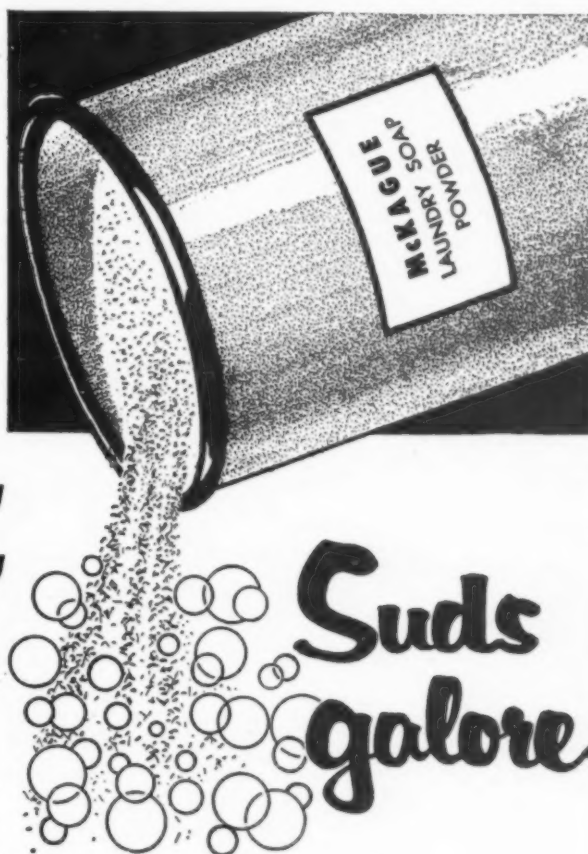
(a) A flush-off by means of warm water streams, utilizing a special insulated shower head with self-closing valve can be accommodated in most table layouts. For this method, the china is placed in the dish-rack and the rack located over a large strainer-equipped sink.

(b) A similar method can be used in combination with a food waste disposer. For this method the china is placed in dish racks and the rack located over a large recess in the soiled dish table, under which is located an electrically driven food waste disposer.

(c) A device known as the "salvador" combines water scrapping and soil collection. The dishes are held under a stream of water of sufficient force to flush off gross

(continued on page 110)

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washing
sparkling
clean



All washing fabrics come bright, clean as new when washed in McKemco Laundry Soap Powder. Its frothy suds go right after dirt and grime . . . scrubbing materials sparkling clean—without affecting quality, colour or tensile strength. You'll have no trouble with rinsing either. McKemco Laundry Soap Powder washes out quickly and easily . . . leaving not a drop of soap in the fabric.

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Dishwashing Machines (continued from page 109)

soil with a minimum of splashing. The water is re-circulated with fresh water being added for dilution purposes. This is an independent unit which is placed in the soiled dish table ahead of the dishwashing machine.

(d) By far the best method of water scrapping is to handle this mechanically by means of a spray-type washing unit with a power-

driven, re-circulating pump. The water is re-circulated in the same manner as the wash compartment of a spray-type dishwashing machine. This unit usually utilizes for its replenishing detergent water supply, the spill over water from the wash tank of the accompanying dishwashing machine. This device is usually a separate unit and is used in conjunction with the standard automatic dishwashing machine so that racks are automatically con-

veyed through the water scrapping unit and then through the dishwashing machine.

Dishwashing machines should be of adequate size. A most important point and one frequently neglected is the necessity for an ample supply of hot water. The machine itself is provided with adequate heating for the wash tank or in the case of the multiple tank machines, for all tanks employed. Often, the fresh hot water supply for the final rinse does not receive adequate consideration. Since this supply usually comes from the regular building supply and since this supply is normally maintained at lower than lethal temperatures, a booster heater or booster recovery system is usually required. These are now available for gas, steam, or electricity. It is important in any installation planning that the heating and plumbing engineers carefully size these booster heaters or booster recovery systems for the particular size of machine being installed. All major dishwashing machine manufacturers provide data concerning rinse water consumption by their respective models. Thermostatic regulators can be provided to control closely the dishwasher wash and rinse tank water temperatures by automatically adjusting the tank heating devices.

New plastic curtains which will wear longer and will not become impregnated with soil and grease are now available for conveyor-type dishwashers, in place of standard duck curtains.

Clean dish tables of sufficient size are essential. These should be provided to allow ample space for air drying of the china prior to unloading. When dishes are washed and rinsed at lethal temperatures, air drying in well ventilated dish pantries can be accomplished in 30 to 45 seconds. With this time as a known factor, the clean dish table can be sized accordingly to suit the particular machine.

General Considerations

There are several general considerations which make for a good installation. Dish rack returns of the sliding or roller type should be employed wherever practical. Proper storage for the racks should be provided during the down-time of the dishwashing operation. All dish pantries should be well ventilated, ceilings sound-proofed if possible and well lighted. An inexpensive paint-on type of sound deadener is available to reduce the noise level

(concluded on page 112)



New "Straightline" for greater load capacity

Advanced Castle engineering now provides a sterilizer design which increases load capacity while reducing sterilizer cost.

That's right! Castle's new "Straightline" Milk Formula Sterilizer, for example, will process 192 bottles per load—just as much as some larger and more expensive Rectangular units.

And the line is complete—from steam-jacketed instrument, dressing and solution sterilizers with exclusive double-backhead, to exclusive single-shell Milk Formula and Laboratory units.

Better still, whether cabinet or recessed, manual or automatic control, every Castle "Straightline" Sterilizer is equipped with the all-protecting Dual Lock Safety Door.

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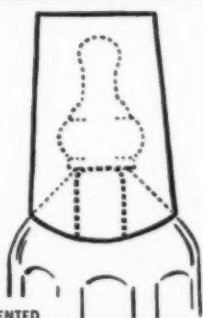
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POST-OP

Dishwashing Machines (concluded from page 110)

of the dish tables. A well designed detergent dispenser should be installed on the re-circulated pumped wash unit because hand feeding of detergent is rarely satisfactory. There are various types of dispensers available from detergent manufacturers which will closely control the concentration of solution. There should be a careful selection of a detergent of adequate quality with chemical components suited to local conditions.

A relatively new device known as a rinse line injector is available, which injects a measured amount of drying agent into the fresh water rinse. This speeds drying and in most cases completely eliminates the necessity for towelling china, glasses and silverware which may otherwise be required due to inadequacy of some of the factors mentioned earlier.

A well designed dishwashing machine is constructed so that it is easy to clean and easy to keep clean. Thorough cleaning can usually be accomplished without the use of any tools. Most dishwashing machine manufacturers provide complete instructions for proper care and cleaning of the machine, sometimes supplying wall charts. Among other things, rinse nozzles, wash arms, wash nozzles and strainers should be regularly cleaned. Most important of all in this respect, however, is the need for supervision to ensure that the established routines and procedures are faithfully followed.

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1. National Sanitation Clinic: Report of the First National Sanitation Clinic. Ann Arbor, National Sanitation Foundation, 1948. 310 pp.
2. National Sanitation Foundation: Report No. 4, pp. 53-70.
3. National Sanitation Foundation: Joint Committee on Food Equipment Standards. Standard No. 3, Ann Arbor, 1953.

Water Safety

- Watch children playing with plastic toys. These are fun on the beach—hazardous in the water. The slightest breeze will carry them out of reach into deep water.
- Because children love to play in water, they must be watched constantly if there are creeks, rivers or ponds, no matter how small, near the home. A ditch, flooded after a storm, can be a death trap.

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Surg. Supplies Ltd.



SYMBOL OF QUALITY

You Were Asking
(continued from page 104)

pital, which is a 53-bed institution.

I have one registered nurse on duty at all times and she is responsible for supervising and helping in the care of the patients. Two registered nurses are on call for the operating room—one to circulate and one to scrub. As there are few registered nurses on staff, I find myself on call much of the time and do not attempt to leave the institution unless I am certain that there

are two other nurses available. Days off and week-ends are taken when I have a competent senior nurse on duty, upon whose administrative judgment I can rely. However, she is always able to reach me by phone. Holidays are dealt with in a similar manner. The senior staff nurse is to use her own discretion in determining what administrative duties must be performed immediately and which may be left until my return. I do my purchasing in advance and try to

organize the work so that she will have a minimum amount to do, as she still has nursing procedures to carry out. I leave a forwarding address for mail, and if possible, give a telephone number also.

I feel that it is essential to be within reach if needed, for the nurse I leave in charge must still perform her nursing duties and cannot give much time to administration, especially with this present shortage of nurses. The number of times I am called back varies, but I do not feel that it is too frequent.—*Dorothy Gruenke, Supt.*

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STAINLESS STEEL
holds temperature for hours

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The Weaker Sex

Man, "becoming positively fragile in mind and body", is breaking down under the relentless pounding of 20th century life. Women who want to stave off widow's weeds as long as possible should marry men at least two or three years younger than themselves.

This lugubrious diagnosis was given by a New York psychologist, Murray Banks, in an address to a women's lodge in Montreal. He also asserted that women are largely under one big pressure . . . to get married; that they adjust better to the "ulcer age" and are mentally and physically much the stronger sex.

"Physically, statistics are proving the superior strength of women. The time has already come when they should give up their seats in buses and trains to the weaker sex".

New Treatment for Arthritis

A new treatment for arthritis is being introduced in Canada at Toronto Western Hospital. Patients going to the hospital's clinic are subjected to an intensive examination of the whole body by Dr. Douglas Taylor, specialist in arthritis and rheumatic diseases, in order to establish a complete diagnosis.

Where the joint is damaged or there is much pain, he theorizes that it needs complete rest and relaxation and that the usual type of exercise frequently adds to the damage. He provides specially designed back rests, splints and collars with which the patient may immobilize the affected joint for several hours at a time. This temporary relaxation of the joints for brief periods effectively cuts down on, in time, may entirely eliminate the pain of the commonest types of arthritis, Dr. Taylor has found.

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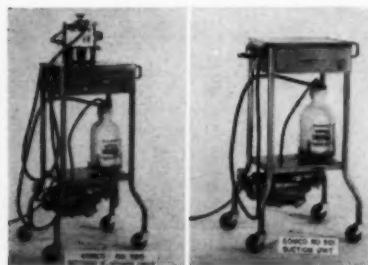
... Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

Improvements in Gomco Equipment

The Gomco Surgical Manufacturing Corp. of Buffalo, New York, has added to its line of hospital, clinic and surgeon's equipment, new, improved stand units for suction and suction-ether service. These explosion-proof units, which provide all the smoothly controlled essential facilities of cabinet models, now bear the Underwriter's Laboratory and C.S.A. Seal for safety, and offer added convenience, beauty and quieter operation.



The No. 900 Suction and Ether unit provides a larger stand—now 15" wide, 11" deep and 34" high from floor to table top. It is graceful and sturdy in design, with Gomco Lunitone Finish, large accessories drawer, soft-tread conductive rubber tired casters, stainless steel top fittings in chrome-plate, making it generally more attractive and serviceable.

The Ether system has a new micrometer-type regulator indicating the ether flow in liters per minute, with the same setting producing the identical rate of flow every time. Another added feature

is Gomco Aerovent overflow protection which automatically prevents suction overflow—the same feature offered in Gomco Cabinet models.

Suction Unit, No. 901, also new in design and with Underwriter's Laboratory and C.S.A. approval, is equipped with the same mobile, non-tipping stand as the 900. It has suction facilities, only but has proved popular with institutions where budget dictates a lower first-cost. The No. 901 also has the Gomco Aerovent overflow valve.

A catalogue and additional descriptive material is available by writing Gomco, 828 E. Ferry Street, Buffalo 11, New York.

New Model Floor Machine Introduced

Balanced heavy-duty construction that provides true ease of handling has been combined with extra-large floor maintenance capacity in the new model PR-22 Master Floor Machine, recently introduced by the Premier Company.

Engineered for rugged maintenance duty involving very large floor areas, the PR-22 daily scrubs, shampoos, waxes, polishes, grinds, sands, buffs or dry cleans floors of 20,000 square feet and more. It is designed for use on all types of floor surfacing, including carpeting.

Powered by a 1 hp General Electric constant speed motor, the unit uses permanently sealed ball bearings which require no lubrication. The machine measures only 12 inches from the floor to top of the motor housing, providing access to hard-to-reach areas, while

the 40-foot cable affords long-range effectiveness.

A complete assortment of accessories and attachments is available for the PR-22 including a solution tank and channel feed brush kit which converts the machine for use as an all purpose mechanized scrubber.



Premier manufactures a complete line of floor machines as well as a full line of vacuum machines. Further information can be obtained by writing or calling Belltower Distributors Limited, Canadian Sales Division of the Premier Company, 35 Gerrard Street West, Toronto, Ontario.

Thomas Gibson Announces New Appointment



T. M. Gibson, chairman, and the board of directors of Thomas Gibson & Company Limited, announce the appointment of S. J. McKenzie, a director, as general manager of the Company, effective immediately.

During Mr. McKenzie's long association with the company, he has been entrusted with the direction of every aspect of its operations. His most recent responsibilities

(continued on page 120)

Use



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CANADA'S FINEST PAPER CUPS

- PORTION CUPS
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There is a Fairbanks-Morse Generating Plant in a capacity for every possible need; each one sturdily built for years of dependable, economical, trouble-free service. Every unit is tested, inspected and guaranteed. Installation is easy as units are shipped completely assembled. Operating costs are low because of Fairbanks-Morse engineering know-how combined with more than 120 years of experience in building mechanical equipment.



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6546 UPPER LACHINE ROAD, MONTREAL 28

Across the Desk (continued from page 118)

have been those of general sales manager, and assistant to the general manager. Mr. McKenzie's extensive knowledge of the company's policies have been of benefit to executives and staffs of hospitals, institutions and industries. He is well known to flooring contractors, as well as purchasers of general sanitation items.

Safe Way To Handle Hydrogen Peroxide

Unbreakable, protected against pressure blow-out, and ICC-approved without costly packing—that's the new, exclusive aluminum container that Fisher uses for its 30 per cent Hydrogen Peroxide in certified reagent (with individual lot analyses), reagent, and technical grades—at no increase in prices.



The pint-sized seamless-aluminum can assures safer, easier handling of the solution, greater stability over a longer period. And it's protected against pressure blowout (the precision-thread screw cap has a slitted plastic safety valve to release excess pressure). Each aluminum can contains one pound of solution—and there are scores of uses for the empties.

Further information available from Fisher Scientific Limited, Montreal 9, Que.

Eric M. Parsons is Garland Representative

Garland-Blodgett Limited announces the appointment of Eric M. Parsons as their Quebec and Maritime Representative. Mr. Parsons has had many years of experience in the kitchen equipment industry and is well known to the trade.

Large Addition to Kendall Plant in Toronto

Construction of a 40,000 square-foot addition to the Kendall Company (Canada) Limited plant in Toronto is planned for this year, according to an announcement by president D. F. Kent.

The new addition will bring the total space occupied to 125,000 square feet, making it one of the largest plants in the East York-O'Connor Drive industrial development region in metropolitan Toronto. A modern textile finishing plant, employing the latest advances in equipment, will be incorporated in the \$750,000 building for the processing of surgical dressings. It will be completed and in production by early 1958.

The new addition will mark the third step in a planned program of expansion, since the present offices and factory were built in 1950, each step increasing space by 50 per cent.

The Kendall Company (Canada) Limited has several well-known operating divisions under the names of Bauer & Black (Curity surgical dressings and Blue Jay foot products); Kendall Mills Division (Curity diapers, absorbent cottons, other textile items); Polyken (Pressure-sensitive adhesive tapes); and Bike (Athletic supports and trainers' supplies).

New Type G. E. Mobile X-Ray Unit

Sharper, clearer x-ray images are made possible by a new-type mobile x-ray unit that features an electronic exposure timer, it is announced by the X-ray Department, General Electric Co., Milwaukee, Wisconsin.

Known as the Mobile "90", the new apparatus is provided with a special electronic circuit that permits split-second timing of the x-ray exposure, greatly minimizing the inconsistencies in exposures and images which plague the radiologist

and x-ray technician in using conventional mobile x-ray units.

Offering up to 90 kilovolts at 15 milliamperes, the device thus permits the use of a small (1.5 mm) effective focal spot, which further enhances image detail and sharpness on the x-ray film.



Equipped with large, ball-bearing, rubber-tired wheels, the mobile x-ray unit can be moved gently over door sills, quietly down corridors, and with ease on to elevators.

Being highly mobile, it is particularly useful for the radiography of patients who are bedridden because of fractures, severe illness, or confinement to oxygen tents, or other special therapeutic devices. The 20" extension of the accordion-type tube-arm makes it easy to extend the tube head over the bedside

(continued on next page)

Johnson & Johnson Appointments

John Macdonald, President of Johnson & Johnson Limited, has announced the following appointments: Philip W. Remington, assistant vice-president, hospital and professional division; Frank M. Falls, director, hospital division; John H. Rowat, director, Ethicon and dental division; Arthur M. Ward, director, orthopaedic division and Fenwal division. Mr. Remington was recently elected to the board of directors of the company.



P. W. Remington

F. M. Falls

J. H. Rowat

A. M. Ward

and to overcome such difficult positioning problems as those caused by complicated fracture-bed framework obstructions.

Purpose of the mobile unit is not only to move x-ray equipment to the patient, but also to simplify such special x-ray problems as examinations of the weight-bearing ankle, with the patient standing on the floor. It thus also serves as an auxiliary unit even within the busy x-ray department.

Dudley Lock Division Moves Toronto Office

Dudley Lock Division, United-Carr Fastener Co. of Canada Limited, have moved to 93 Yorkville Avenue, Toronto 5. They are the well-known manufacturers of Dudley Combination Locks, which are widely used in hospitals, schools and in industrial plants.

Oxygen Flowmeter Contaminated With Oil

Recently when a flowmeter that had been returned for repairs was examined, oil was found inside the flowmeter walls and faces. A representative of the oxygen supplier immediately made a call on the hospital from which the flowmeter had come to determine how the flowmeter had become contaminated with oil.

He learned that the flowmeter, which had come from the pediatrics ward, had last been used together with an air compressor to deliver a mixture of air and oxygen to a hood. A hose from the compressor and one from the flowmeter had been joined at a Y-fitting that was connected to a large humidifier.

Examination of the equipment showed that the compressor was oil lubricated and that some oil had passed into the hose leading from the compressor and also into the oxygen hose. Evidently the pressure of the air had been greater than that of the oxygen and had flowed back up the oxygen line. (Probably the pressure had stopped the flow of oxygen completely.) This back flow into the oxygen line of air contaminated with oil could have caused a serious accident.

If compressed air is needed for an inhalation therapy treatment, it is important, for safety, to use air from a cylinder whose label states that it is oil free.—*From Bulletin issued by Linde Air Products Co., Toronto 7, Ont.*



How to SPEED UP Central Service packaging

Seal and label in one quick motion with convenient self-sticking **Time Autoclave Labels**. Cut work in half... eliminate extra folding, tucking and tying. Increase safety with highly legible standard names and sizes.

Economical repeated use... Time Autoclave Labels are good for 4 or 5 trips thru the autoclave... stick firmly to cloth, paper, plastic, metal and all wrappings... without infectious tongue-licking.

Over 500 Labels to choose from... sterile packs, gloves, instruments—everything you handle in Central Service and OR room... and if you want special labels we will print them at a small extra cost.



Now! New Multiple Dispenser FREE
(holds 8 rolls of labels), with
purchase of 48 rolls or more.

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